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REPT. 99-265
Part 1

MEDICARE AND MEDICAID BUDGET RECONCILIATION AMENDMENTS OF 1985

SEPTEMBER 11, 1985.—Ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 3101 which on July 30, 1985, was divided and referred as follows: Section 1 and titles I and II to the Committee on Energy and Commerce; section 1 and title I to the Committee on Ways and Means]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3101) to amend titles XVIII and XIX of the Social Security Act to provide for budget reconciliation, and improvements, with respect to the Medicare and Medicaid Programs, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE: TABLE OF CONTENTS.

This Act may be cited as the "Medicare and Medicaid Budget Reconciliation Amendments of 1985".

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TITLE I—MEDICARE PROGRAM

PART A—CHANGES RELATING PRIMARILY TO PART B OF THE MEDICARE PROGRAM

Group 1

SEC. 101. EXTENSION OF PHYSICIAN FEE FREEZE FOR CERTAIN NON-PARTICIPATING PHYSICIANS AND IMPROVEMENTS IN THE PARTICIPATING PHYSICIAN PROGRAM.

(a) ONE-YEAR EXTENSION FOR NON-PARTICIPATING PHYSICIANS.—

(1) EXTENSION.—Section 1842(b)(4) of the Social Security Act (42 U.S.C. 1395u(b)(4)) is amended—

(A) in subparagraph (A)—

(i) by inserting "(i)" after "(4)(A)", and

(ii) by adding at the end the following new clauses:

"(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983; except that in the case of a physician described in subparagraph (E)(i), the Secretary shall not set any level higher than the increase percentage (described in subparagraph (E)(ii)) above the level that was set for the 12-month period beginning July 1, 1983.

"(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after October 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous fiscal year for physicians who were participating physicians on the last day of that year; except that in the case of a physician described in subparagraph (E)(i), the Secretary shall not set any level higher than the increase percentage (described in subparagraph (E)(ii)) above the level that was set for services furnished during the previous fiscal year for physicians who were participating physicians on the last day of that year.";

(B) in subparagraph (B)—

(i) by inserting "(i)" after "(B)", and

(ii) by adding at the end the following new clause:

"(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983; except that in the case of a physician described in subparagraph (E)(i), the customary charges may not exceed the customary charges that were recognized under this section for the 12-month period beginning July 1, 1983, increased by the increase percentage (described in subparagraph (E)(ii)).";

(C) in subparagraph (C)—

(i) by inserting "(i)" after "(C",

(ii) by striking out "(A)" and inserting in lieu thereof "(A)(i)" each place it appears, and

(iii) by adding at the end the following new clause:

"(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).";

(D) in subparagraph (D)—

(i) by striking out "who at no time" and all that follows through "subsection (h)(1))" and insert in lieu thereof "who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985",

(ii) by inserting "(i)" after "(D)", and

(ii) by adding at the end the following new clause:

"(ii)(I) In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1986, or October 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on September 30, 1986, except as provided in subclause (II) the Secretary shall not recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

"(II) In the case of a physician who was a participating physician on September 30, 1985, the Secretary shall recognize increases in actual charges for service furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984, but only to the extent that the percentage of such increase does not exceed one-half of the percentage increase in the physician's actual charges for services furnished over the period beginning July 1, 1984, and ending September 30, 1985,"; and

(E) by adding at the end the following new subparagraph:

"(E)(i) With respect to services furnished during a 12-month period beginning on October 1, a physician described in this clause is a physician who is not a participating physician at the time of furnishing the services but who either (I) was a partici-

pating physician on September 30 before that period, or (II) accepted payment on an assignment-related basis (as defined in subsection (h)(80)) for all claims received during the immediately preceding 12-month period for service furnished by the physician under this part during that period.

"(ii) The 'increase percentage' described in this clause is, with respect to a physician for items and services furnished during a 12-Month period beginning on October 1, one-half of the percentage increase that otherwise would be applicable to services furnished by the physician if the physician (I) had been a participating physician on the date before the first date of the period, and (II) were to sign up to be a participating physician for items and services furnished during the period.".

(2) CONTINUED ENFORCEMENT.—Section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) is amended—

(A) by amending the first sentence to read as follows: "In the case of a physician who is not a participating physician for items and services furnished during a portion of the 27-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period."; and

(B) in the second sentence, by inserting ", or, in the case of items and services furnished during fiscal year 1986 by a physician who was a participating physician on September 30, 1985, if such physician knowingly and willfully bills individuals enrolled under this part for actual charges which are more than the increase percentage (which may be recognized under subparagraph (D)(ii)(II)) above such physician's actual charges for the calendar quarter beginning on April 1, 1984" after "April 1, 1984".

(3) EFFECTIVE DATE.—The amendment made by this subsection shall apply to services furnished on or after October 1, 1985.

(b) INCENTIVES FOR PARTICIPATING PHYSICIAN PROGRAM.—

(1) ONE-YEAR EXTENSION OF TRANSFER OF FUNDS FOR CARRIERS.—Section 230(e) of the Deficit Reduction Act of 1984 (Public Law 98-369; Stat. 1073) is amended—

(A) by striking out "and 1985" and inserting in lieu thereof ", 1985, and 1986",

(B) by striking out "the amendments made by this section" and inserting in lieu thereof "subsections (b)(4), (h), and (j) of section 1842 of the Social Security Act",

(C) by striking out "for fiscal year 1985" and inserting in lieu thereof "for each of fiscal years 1985 and 1986", and

(D) by adding at the end the following new sentence: "A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program.".

(2) IMPROVEMENT OF PARTICIPATING PHYSICIAN DIRECTORIES.—Section 1842(i) of the Social Security Act (42 U.S.C. 1395u(i)) is amended—

(A) in the first sentence of paragraph (2)—

(i) by striking out "a directory" and inserting in lieu thereof "directories (for appropriate local geographic areas)", and

(ii) by inserting "for that area" before "for that fiscal year";

(B) in the second sentence of paragraph (2), by striking out "The directory" and inserting in lieu thereof "Each directory";

(C) in paragraph (3)—

(i) by striking out "directory" the first place it appears and inserting in lieu thereof "the directories", and

(ii) by striking out "directory" the second place it appears and inserting in lieu thereof "the appropriate area directory or directories";

(D) in paragraph (4)—

(i) by striking out "directory" and inserting in lieu thereof "the directories", and

(ii) by adding at the end the following: "The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area.".

(3) ELIMINATION OF PHYSICIAN ASSIGNMENT RATE LIST.—Section 1842(i) of such Act is further amended—

(A) by striking out "(i)(1)" and all that follows through the end of paragraph (1),

(B) by striking out "subsection (h)(1)" in paragraph (2) and inserting in lieu thereof "paragraph (1)",

(C) by striking out "such list and" and "the list and" each place either appears in paragraphs (3) and (4), and

(D) by redesignating paragraphs (2) through (4), as paragraphs (4) through (6) of subsection (h), respectively.

(4) INFORMATION ON THE PARTICIPATING PHYSICIAN AND SUPPLIER PROGRAM IN EXPLANATIONS OF MEDICARE BENEFITS FOR UNASSIGNED CLAIMS.—Section 1842(h) of such Act, as previously amended by this subsection, is further amended by adding at the end the following new paragraphs:

"(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—

"(A) a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and

"(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which a beneficiary may obtain information on participating physicians and suppliers.

"(8) For purposes of this title, a claim is considered to be paid on an 'assignment-related basis' if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).".

(5) EFFECTIVE DATE.—Section 1842(b)(7) of the Social Security Act, as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than April 1, 1986) as the Secretary of Health and Human Services shall specify.

SEC. 102. PHYSICIAN PAYMENT REVIEW COMMISSION AND DEVELOPMENT OF RELATIVE VALUE SCALE.

(a) ESTABLISHMENT OF COMMISSION.—Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"PHYSICIAN PAYMENT REVIEW COMMISSION

"SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to the 'Director' and the 'Office', respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of physicians' services appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed no later than December 1, 1985, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (in a continuing basis) the terms of no more than four members expire in any one year.

"(3) The membership of the Commission shall include physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly. The Director shall seek nominations from a wide range of groups, including—

"(A) national organizations representing physicians, including medical specialty organizations,

"(B) organizations representing the elderly and consumers,

"(C) national organizations representing medical schools,

"(D) national organizations representing hospitals, including teaching hospitals, and

"(E) national organizations representing health benefits programs.

"(b)(1) The Commission shall make recommendations to the Congress, not later than February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

"(2) In making its recommendations, the Commission shall—

"(A) consider, and make recommendations on the feasibility and desirability of reducing, the differences in payment amounts for physicians' services under this part which are based on differences in geographic location or specialty;

"(B) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

"(C) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of subparagraphs (A) and (B);

"(D) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

"(E) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

"(F) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under this part based on (i) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related groups) and (ii) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under this part);

"(G) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

"(H) identify those procedures for which an opinion of a second physician should be required before payment is made under this title; and

"(I) evaluate the method for calculating the number of full-time-equivalent residents set forth in section 1902(h)(4)(D) and make recommendations regarding revisions in, or alternatives to, that method.

"(3) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under subsection (e).

"(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

"(A) Subparagraph (C) (relating to staffing and administration generally).

"(B) Subparagraph (D) (relating to compensation of members).

"(C) Subparagraph (F) (relating to access to information).

"(D) Subparagraph (G) (relating to reports and use of funds).

"(E) Subparagraph (H) (relating to periodic GAO audits).

"(F) Subparagraph (J) (relating to request for appropriations).

"(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and

"(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.".

(b) DEVELOPMENT OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES.—Section 1845 of the Social Security Act, as added by subsection (a), is further amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part or under State plans approved under title XIX.

"(2) In developing the scale, the Secretary shall consider among other items—

"(A) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

"(B) the recommendations of the Physician Payment Review Commission under subsection (b)(3), and

"(C) factors with respect to the input costs for furnishing particular physicians' services, such as—

"(i) the differences in costs of furnishing services in different settings,

"(ii) the differences in skill levels and training required to perform the services, and

"(iii) the time required, and risk involved, in furnishing different services.

"(3) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than April 1, 1987. The report shall include recommendations for the application of the scale to payment for physicians' services furnished under this part on or after October 1, 1987.".

SEC. 103. PART B PREMIUM.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (e), by striking out "1988" and inserting in lieu thereof "1989" each place it appears;

(2) in subsection (f)(1), by striking out "or 1986" and inserting in lieu thereof ", 1986, or 1987"; and

(3) in subsection (f)(2), by striking out "or 1987" and inserting in lieu thereof ", 1987, or 1988".

SEC. 104. DETERMINATIONS OF INHERENT REASONABLENESS OF CHARGES AND CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS.

(a) REGULATIONS RELATING TO INHERENT REASONABLENESS OF CHARGES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(8) The Secretary by regulation shall—

"(A) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

"(B) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.".

(b) COMPUTATION OF CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS.—(1) In applying section 1842(b) of the Social Security Act for payment for physicians' services performed during fiscal year 1986, in the case of a physician who during the period beginning on October 31, 1982, and ending on January 31, 1985, was a hospital-compensated physician (as defined in paragraph (2)) but who, as of January 31, 1985, was no longer a hospital-compensated physician, the physician's customary charges shall—

(A) be based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985, and

(B) in the case of a physician who is not a participating physician (as defined in section 1842(h)(1) of the Social Security Act) on October 1, 1985, be deflated (to take into account the legislative freeze on actual charges for nonparticipating physicians' services) by multiplying the physician's customary charges by .83.

(2) In paragraph (1), the term "hospital-compensated physician" means, with respect to services furnished to patients of a hospital, a physician who is compensated by the hospital for the furnishing of physicians' services for which payment may be made under this part.

SEC. 105. OCCUPATIONAL THERAPY SERVICES.

(a) COVERAGE.—Subparagraph (C) of section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended to read as follows:

"(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));".

(b) LIMITATION ON PAYMENTS.—Section 1833(g) of such Act (42 U.S.C. 13951(g)) is amended—

(1) by striking out "next to last sentence" and inserting in lieu thereof "second sentence", and

(2) by adding at the end thereof the following new sentence: "In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).".

(c) CERTIFICATION STANDARD.—(1) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)(C)) is amended—

(A) by inserting "or outpatient occupational therapy services" after "outpatient physical therapy services",

(B) in clause (i), by inserting "or occupational therapy services, respectively" after "physical therapy service", and

(C) in clause (ii), by inserting "or qualified occupational therapist, respectively" after "qualified physical therapist".

(2) The second sentence of section 1835(a) of such Act and section 1866(e) of such Act (42 U.S.C. 1395n(a), 1395cc(e)) are each amended—

(A) by inserting "(or meets the requirements of such section through the operation of section 1861(g))" after "1861(p)(4)(A)" and after "1861(p)(4)(B)", and

(B) by inserting "or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

(d) DEFINITION AND INCLUSION WITH OTHER PART B SERVICES.—(1) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by inserting after subsection (f) the following new subsection:

"OUTPATIENT OCCUPATIONAL THERAPY SERVICES

"(g) The term 'outpatient occupational therapy services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that 'occupational' shall be substituted for 'physical' each place is appears therein.".

(2) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting "and outpatient occupational therapy services" after "outpatient physical therapy services".

(3) Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting "(including through the operation of section 1861(g))" after "section 1861(p)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for outpatient occupational therapy services furnished on or after October 1, 1985.

SEC. 106. PAYMENT FOR DURABLE MEDICAL EQUIPMENT.

(a) FREEZING CUSTOMARY AND PREVAILING CHARGES FOR ITEMS FURNISHED ON RENTAL BASIS AND HOME OXYGEN SERVICES.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

"(k)(1) In determining the customary and prevailing charge levels under the third and fourth sentences of subsection (b)(3)—

"(A) for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement), and

"(B) for oxygen therapy services furnished,

during the 12-month period beginning on October 1, 1985, the Secretary shall not set any such level higher than the same level as was set for the 15-month period beginning July 1, 1984. As used in this subsection, the term 'oxygen therapy services' means durable medical equipment, accessories, and supplies for the provision of oxygen therapy in a patient's home.".

(b) REQUIRING PAYMENT ON AN ASSIGNMENT BASIS FOR DURABLE MEDICAL EQUIPMENT FURNISHED ON A RENTAL BASIS AND FOR OXYGEN THERAPY SERVICES.—Section 1842(k) of such Act, as added by subsection (a), is amended by adding at the end the following new paragraph:

"(2) Payment under this part for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) and for oxygen therapy services may only be made on an assignment-related basis (as defined in subsection (h)(8)) or to a provider of services with an agreement in effect under section 1866.".

(c) LIMITING INCREASE IN PREVAILING CHARGES FOR DURABLE MEDICAL EQUIPMENT TO CONSUMER PRICE INDEX.—Section 1842(k) of such Act, as previously amended, is further amended by adding at the end the following new paragraph:

"(3) In the case of durable medical equipment, the prevailing charge levels determined for purposes of clause (ii) of the third sentence of subsection (b) for any 12-month period (beginning after September 30, 1986) may not exceed (in the aggregate) the levels determined under such clause (taking into account paragraph (1), if applicable) for the preceding 12-month period by a percentage which exceeds the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average), as published by the Secretary of Labor, for the 12-month period ending in March of that preceding 12-month period.".

(d) CLARIFICATION OF PREVIOUS EFFECTIVE DATE.—Section 2306(b)(2) of the Deficit Reduction Act of 1984 is amended by adding before the period at the end the following: "and to durable medical equipment furnished on or after July 1, 1985".

(e) EFFECTIVE DATES.—

(1) SUBSECTION (a).—The amendments made by subsection (a) shall apply to durable medical equipment (including oxygen therapy services) furnished on or after October 1, 1985.

(2) SUBSECTION (b).—The amendments made by subsection (b) shall apply to durable medical equipment furnished on or after January 1, 1986.

(3) SUBSECTION (c).—The amendments made by subsection (c) shall apply to durable medical equipment furnished on or after October 1, 1986.

(4) SUBSECTION (d).—The amendment made by subsection (d) shall take effect as though it were included in the enactment of the Deficit Reduction Act of 1984.

SEC. 107. PAYMENT FOR ASSISTANTS AT SURGERY FOR CERTAIN CATARACT OPERATIONS AND OTHER OPERATIONS.

(a) LIMITATION ON PAYMENT.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking out "or" at the end of paragraph (13),

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof "; or", and

(3) by adding at the end the following new paragraph:

"(15) which are for services of an assistant at surgery in a cataract operation unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition.".

(b) ADDITIONAL PRO FUNCTIONS.—Section 1154(a)(8) of such Act (42 U.S.C. 1320c–3(a)(8)) is amended by inserting before the period at the end the following: "or as may be required to carry out section 1862(a)(15)".

(c) PROHIBITION FOR SUBMITTING BILL FOR WHICH PAYMENT MAY NOT BE MADE.—Section 1842 of such Act (42 U.S.C. 1395u) is amended—

(1) in subsection (j)(2), by inserting "or subsection (1)" after "paragraph (1)", and

(2) by adding after subsection (k), as added by section 106(a) of this title, the following new subsection:

"(l)(1) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(2) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).".

(d) EXTENSION OF PROHIBITION TO OTHER PROCEDURES.—The Secretary of Health and Human Services, after consultation with the Physician Payment Review Commission, shall develop recommendations and guidelines respecting other surgical procedures for which an assistant at surgery is generally not medically necessary and the circumstances under which the use of an assistant surgeon is medically appropriate with prior approval of an appropriate entity. The Secretary shall report to Congress, not later than April 1, 1986, on these recommendations and guidelines.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services performed on or after October 1, 1985.

SEC. 108. LIMITATION ON MEDICARE PAYMENT FOR POST-CATARACT SURGERY PATIENTS.

(a) PAYMENT FOR REPLACEMENT OF LOST OR DAMAGED CATARACT EYEGLASSES AND CATARACT CONTACT LENSES.—With respect to the payment for replacement cataract eyeglasses and cataract contact lenses under title XVIII of the Social Security Act in the case of an individual beneficiary—

(1) payment may be made for the replacement only once every year of lost or damaged cataract eyeglasses, and

(2) payment may be made—

(A) in the first year after surgery, for one original cataract contact lens for each eye and for the replacement only twice of a lost or damaged cataract contact lens for each eye, and

(B) in each subsequent year, for the replacement only twice of a lost or damaged cataract contact lens for each eye.

(b) DETERMINATION OF SEPARATE PAYMENT AMOUNTS FOR PROSTHETIC LENSES AND PROFESSIONAL SERVICES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding after paragraph (8), added by section 104(a) of this Act, the following new paragraph:

"(9) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

"(A) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services, and

"(B) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.".

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall apply to items and services furnished on or after October 1, 1985.

(2) In applying the amendment made by subsection (a), there shall not be taken into account any cataract eyeglasses or contact lenses replaced before October 1, 1985.

SEC. 109. DEMONSTRATION OF PREVENTIVE HEALTH SERVICES UNDER MEDICARE.

(a) DEMONSTRATION PROGRAM.—The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under title XVIII of the Social Security Act (hereinafter in this section referred to as "medicare beneficiaries").

(b) PREVENTIVE HEALTH SERVICES UNDER DEMONSTRATION PROGRAM.—The preventive health services to be made available under the demonstration program shall include—

(1) health screenings,
(2) health risk appraisals,
(3) immunizations, and
(4) counseling on and instruction in—
(A) diet and nutrition,
(B) reduction of stress,
(C) exercise and exercise programs,
(D) sleep regulation,
(E) injury prevention,
(F) prevention of alcohol and drug abuse,
(G) prevention of mental health disorders,
(H) self-care, including use of medication, and
(I) reduction of smoking.

(c) CONDUCT OF PROGRAM.—The demonstration program shall—

(1) be conducted under the direction of accredited public or private nonprofit schools of public health;

(2) be conducted in no fewer than five sites, which sites shall be chosen so as to geographically diverse and shall be readily accessible to a significant number of medicare beneficiaries;

(3) involve community outreach efforts at each site to enroll the maximum number of medicare beneficiaries in the program; and

(4) be designed—

(A) to test alternative methods of payment for preventive health services, including payment on a prepayment basis as well as payment on a fee-for-services basis,

(B) to permit a variety of appropriate health care providers to furnish preventive health services, including physicians, health educators, nurses, allied health personnel, dieticians, and clinical psychologists, and

(C) to facilitate evaluation under subsection (d).

(d) EVALUATION.—The Secretary shall evaluate the demonstration project in order to determine—

(1) the short-term and long-term costs and benefits of providing preventive health services for medicare beneficiaries, including any reduction in inpatient services resulting from providing the services, and

(2) what practical financing mechanisms exist to provide payment for preventive health services under title XVIII of the Social Security Act.

(e) REPORTS TO CONGRESS.—(1) Not later than three years after the date of the enactment of this Act, the Secretary shall submit a preliminary report to the Committees on Ways and Means and on Energy and Commerce of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the

demonstration program, including a description of the sites at which the program is being conducted and the preventive health services being provided at the different sites.

(2) Not later than five years after the date of the enactment of this Act, the Secretary shall submit a final report to those Committees on the demonstration program and shall include in the report—

(A) the evaluation described in subsection (d), and

(B) recommendations for appropriate legislative changes to incorporate payment for cost-effective preventive health services into the medicare program.

(f) FUNDING.—Expenditures made for the demonstration program shall be made from the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

Group 2

SEC. 111. PAYMENT FOR CLINICAL LABORATORY SERVICES.

(a) CHANGING MONTH OF ANNUAL UPDATE FROM JULY TO OCTOBER.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act (42 U.S.C. 13951(h)) is amended—

(A) by striking out "June 30, 1987" and "July 1, 1987" and inserting in lieu thereof "September 30, 1987" and "October 1, 1987", respectively, each place either appears, and

(B) in paragraph (2), by inserting "(to become effective on October 1 of each year)" after "adjusted annually".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to clinical laboratory diagnostic tests performed on or after July 1, 1986.

(3) TRANSITION.—The Secretary of Health and Human Service shall provide that the annual adjustment under section 1833(h) of the Social Security Act for 1986—

(A) shall take effect on October 1, 1986,

(B) shall apply for the 12-month period beginning on that date, and

(C) shall take into account the percentage increase or decrease in the Consumer Price Index for all urban consumers (United States city average) occurring over a 15-month period, rather than over a 12-month period.

(b) PROVIDING CEILING ON RATES.—

(1) CEILING ON PAYMENTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 13951(a)) are each amended by inserting after "lesser of the amount determined under such fee schedule" the following: ", the limitation amount for that test determined under subsection (h)(4)(B),".

(2) ESTABLISHMENT OF LIMITATION AMOUNT.—Section 1833(h)(4) of such Act is amended by inserting "(A)" after "(4)" and by adding at the end the following new subparagraph:

"(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

"(i) on or after January 1, 1986, and before October 1, 1986, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1), or

"(ii) after September 30, 1986, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to 110 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to clinical diagnostic laboratory tests performed on or after January 1, 1986.

(c) REPORT ON MINIMUM STANDARDS FOR CLINICAL LABORATORIES THAT ARE PART OF, OR ASSOCIATED WITH, PHYSICIANS' OFFICES.—The Secretary of Health and Human Services shall report to Congress, not later than 12 months after the date of the enactment of this Act, on the standards that might be established under the medicare program for clinical laboratories which are part of or associated with a physician's office to assure the health and safety of individuals with respect to whom the laboratories perform clinical diagnostic laboratory tests for which pay-

ment may be made under the program. In recommending standards, the Secretary shall consider the differences in the scope, type, and complexity of tests performed by such laboratories and such other factors as may indicate a need for different standards for laboratories with different characteristics.

SEC. 112. VISION CARE.

(a) DEFINING SERVICES AN OPTOMETRIST CAN PROVIDE.—Clause (4) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) is amended to read as follows: "(4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1986.

PART B—CHANGES RELATING TO PARTS A AND B OF THE MEDICARE PROGRAM

Group 1

SEC. 121. EXTENSION OF WORKING AGED PROVISIONS TO INDIVIDUALS OVER 69.

(a) EXTENSION OF MEDICARE AS SECONDARY PAYOR.—Section 1862(b)(3)(A) of the Social Security Act (42 U.S.C. 1395y(b)(3)(A)) is amended—

(1) in clause (i), by striking out "who is under 70 years of age during any part of such month" and ", if the spouse is under 70 years of age during any part of such month", and

(2) in clause (iii), by striking out "and ending with the month before the month in which such individual attains the age of 70".

(b) EXTENSION OF ANTI-DISCRIMINATION PROVISIONS.—

(1) Section 4(g)(1) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(g)(1)) is amended by stiking out "through 69" and inserting in lieu thereof "or older" each place it appears.

(2) Section 12(a) of such Act (29 U.S.C. 631(a)) is amended by inserting "(except the provisions of section 4(g))" after "Act".

(c) CONFORMING AMENDMENTS.—

(1) SPECIAL ENROLLMENT PERIOD.—Paragraph (3) of section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)(3)) is amended to read as follows:

"(3) The special enrollment period referred to in paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later.".

(2) EFFECTIVE DATE OF ENROLLMENT.—Subsection (e) of section 1838 of the Social Security Act (42 U.S.C. 1395q) is amended to read as follows:

"(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—

"(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

"(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls."

(d) EFFECTIVE DATES.—(1) The amendments made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 1986.

(2) The amendments made by subsection (b) shall become effective on January 1, 1986.

(3) The amendments made by subsection (c) shall take effect on January 1, 1986, but shall not apply to any individual with respect to whom a special enrollment period under section 1837(i)(3) began before that date.

SEC. 122. PROVISIONS RELATING TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) FINANCIAL RESPONSIBILITY FOR PATIENTS HOSPITALIZED ON THE EFFECTIVE DATE OF AN ENROLLMENT OR DISENROLLMENT.—(1) Subsection (c) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new paragraph:

"(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B) as of the effective date of the individual's—

"(A) enrollment with an eligible organization under this section—

"(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

"(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

"(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

"(B) terminaton of enrollment with an eligible organization under this section—

"(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

"(ii) payment for such services during the stay shall not be made under section 1886(d), and

"(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.".

(2) Subsection (a)(3) of such section is amended by striking out "Payments" and inserting in lieu thereof "Subject to subsection (c)(7), payments".

(3) Subsection (a)(6) of such section is amended by striking out "If" and inserting in lieu thereof "Subject to subsection (c)(7), if".

(b) DISENROLLMENTS.—

(1) EFFECTIVE DATE.—Subsection (c)(3)(B) of such section is amended by striking out "a full calendar month after" and inserting in lieu thereof "the date on which".

(2) INFORMATION.—Such subsection is further amended by adding at the end the following: "In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.".

(c) REVIEW OF MARKETING MATERIAL.—Subsection (c)(3)(C) of such section is amended by adding at the end the following: "No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.".

(d) PROMPT PUBLICATION OF AAPCC.—Subsection (a)(1)(A) of such section is amended by inserting after "The Secretary shall annually determine" the following: ", and shall publish not later than September 7 before the calendar year concerned".

(e) EFFECTIVE DATES.—

(1) FINANCIAL RESPONSIBILITY.—The amendments made by subsection (a) shall apply to enrollments and disenrollments that become effective on or after October 1, 1985.

(2) DISENROLLMENTS.—The amendments made by subsection (b) shall apply to requests for termination of enrollment submitted on or after October 1, 1985.

(3) MATERIAL REVIEW.—(A) The amendment made by subsection (c) shall not apply to material which has been distributed before October 1, 1985.

(B) Such amendment also shall not apply so as to require the submission of material which is distributed before November 15, 1985.

(C) Such amendment shall also not apply to material which the Secretary determines has been prepared before the date of the enactment of this Act and for which a commitment for distribution has been made, if the application of such amendment would constitute a hardship for the organization involved.

(4) PUBLICATION.—The amendment made by subsection (d) shall apply to determinations of per capita rates of payment for 1987 and subsequent years.

(5) NECESSARY MODIFICATION OF CONTRACTS.—The Secretary of Health and Human services shall provide for such changes in the risk-sharing contracts which have been entered into under section 1876 of the Social Security Act as may be necessary to conform to the requirements imposed by the amendments made by this section on a timely basis.

SEC. 123. EVALUATION OF PREADMISSION AND PRE-PROCEDURE CERTIFICATION PROGRAMS.

(a) EFFECTIVENESS OF 100 PERCENT REVIEW.—The Secretary of Health and Human Services shall evaluate the relative effectiveness of peer review organizations that require preadmission certification of 100 percent of elective inpatient surgical procedures with other peer review organizations that require such certification of a lesser percentage of such procedures.

(b) FEASIBILITY OF PRE-PROCEDURE CERTIFICATION FOR OUTPATIENT SURGICAL PROCEDURES.—The Secretary also shall evaluate the feasibility of extending the pre-procedure certification activities of peer review organizations to cover elective surgical procedures conducted in outpatient and ambulatory care settings. In doing the evaluation, the Secretary shall consider the extent to which entities with contracts with the Secretary under section 1842 of the Social Security Act and other entities might perform such activities more efficiently and effectively than peer review organizations.

(c) REPORT.—The Secretary shall report to Congress, not later than December 31, 1986, on the results of the evaluations conducted under this section.

(d) DEFINITIONS.—In this section, the term "peer review organization" means a ulitization and quality control peer review organization with a contract under part B of title XI of the Social Security Act.

SEC. 124. PROHIBITION OF ADMINISTRATIVE MERGER OF RENAL DISEASE NETWORKS WITH OTHER ORGANIZATIONS.

The Secretary of Health and Human Services may not provide for the merger of any renal disease network (established under section 1881(c) of the Social Security Act) into a utilization and quality control peer review organization (with a contract under part B of title IX of such Act) or another entity without express statutory authorization.

SEC. 125. TECHNICAL CORRECTIONS.

(a) WORKING AGED TECHNICAL CORRECTIONS.—

(1) PREMIUM PENALTY.—The second sentence of section 1839(b) of the Social Security Act (42 U.S.C 1395r(b)), as amended by section 2338(a) of the Deficit Reduction Act of 1984, is amended by strikig out "months in which" and all that follows through "clause (iv) of such section" and inserting in lieu thereof "months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv)".

(2) SPECIAL ENROLLMENT PERIODS.—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p), as added by section 2338(b) of the Deficit Reduction Act of 1984, is amended—

(A) in paragraph (1), by amending subparagraph (A) to read as follows: "(A) has attained the age of 65,"; and

(B) in paragraph (2), by redesignating subparagraph (C) as subparagraph (D) and by amending subparagraphs (A) and (B) to read as follows:

"(A) has attained the age of 65;

"(B)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(B);

"(C) has enrolled in such program during any subsequent special enrollment period under his subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment; and".

(3) EFFECTIVE DATES.—

(A) The amendment made by paragraph (1) shall apply to months beginning with January 1983 from premiums for months beginning with the first month that begins more than 30 days after the date of the enactment of this Act.

(B)(i) The amendments made by paragraph (2) shall apply to enrollments in months beginning with the first effective month (as defined in clause (ii)), except that in the case of any individual who would have a special enrollment period under section 1837(i) of the Social Security Act that would have begun after November 1984 and before the first effective month, the period shall be deemed to begin with the first day of the first effective month.

(ii) For purposes of clause (i), the term "first effective month" means the first month that begins more than 90 days after the date of the enactment of this Act.

(b) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1)(A) Subclause (III) of section 1842(b)(7)(B)(ii) of the Social Security Act (42 U.S.C. 1395u(b)(7)(B)(ii)), as added by section 2307(a)(2)(G) of the Deficit Reduction Act of 1984, is amended by indenting it two additionals ems to the right so as to align its left margin with the left margins of subclauses (I) and (II) of that section.

(B) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)), as inserted by section 2321(e)(3) of the Deficit Reduction Act of 1984, is amended by striking out "at his home" and inserting in lieu thereof "as his home".

(C) Section 1888(b) of the Social Security Act (42 U.S.C. 1395yy(b)), as added by section 2319(b) of the Deficit Reduction Act of 1984, is amended by striking out "nothwithstanding" and inserting in lieu thereof "notwithstanding".

(D) The amendments made by this paragraph shall be efective as if they had been originally included in the Deficit Reduction Act of 1984.

(2)(A) Clause (iii) of section 1842(b)(7)(B) of the Social Security Act (42 U.S.C. 1395u(b)(7)(B)), as added by section 3(b)(6) of Public Law 98-617, is amended by moving its alignment two additionals ems to the left so as to align its left margin with the left margins of clauses (i) and (ii) of that section.

(B) The amendment made by subparagraph (A) shall be effective as if it had been originally included in Public Law 98-617.

(3)(A) Section 1861(v)(1)(G)(i)) of the Social Security Act (42 U.S.C. 1395x(b)(1)(G)(i)), as amended by section 602(d)(1) of the Social Security Amendments of 1983, is amended by inserting in the matter after subclause (III), "on the basis of" after "(during such period)".

(B) The amendment made by subparagraph (A) shall be effective as if it had been originally included in the Social Security Amendments of 1983.

Group 2

SEC. 131. SECOND OPINIONS.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

"SECOND OPINIONS FOR CERTAIN SURGICAL PROCEDURES

"SEC. 1890. (a) CONDITION OF PAYMENT.—No payment shall be made under part A or part B with respect to items or services furnished in connection with a surgical procedure listed by the Secretary pursuant to this section unless the individual undergoing the procedure obtains a second opinion as to the necessity and appropriateness of such procedure, in accordance with this section. For purposes of determining whether an opinion is the second opinion, the first opinion must be made by a physician who is qualified to perform the surgical procedure, and the second opinion is any subsequent opinion made by a physician of the appropriate speciality, as determined under subsection (b)(3). Such second opinion need not necessarily agree with the first opinion in order for payment to be made.

"(b) SURGICAL PROCEDURES TO WHICH CONDITION APPLIES.—

"(1) SECRETARY TO ESTABLISH LIST.—The Secretary shall establish a list of not less than 10 surgical procedures to which the requirements of this section shall apply. The Secretary shall establish such list based upon the following criteria:

"(A) The procedure is one which generally can be postponed without undue risk to the patient.

"(B) The procedure is a high volume procedure among patients who are covered under the programs established under this title, or is a high cost procedure.

"(C) The procedure has a comparatively high rate of nonconfirmation upon requesting a second opinion, based upon data available to the Secretary from any sources.

"(2) LIST VARIATIONS.—The Secretary may vary the list on a State-by-State basis, or within areas of a State, if data available with regard to volume and costs of procedures suggest that to do so would be cost effective and would better serve the purposes of this section.

"(3) LIST TO SPECIFY SPECIALISTS WHO MUST RENDER SECOND OPINION.—The Secretary shall specify, for each procedure on a list established under this subsection, the type or types of board certified or board eligible specialists who must be consulted for the second opinion, based upon the nature of the procedure.

"(c) REFERRAL MECHANISM FOR SECOND OPINIONS.—

"(1) USE OF PRO AS REFERRAL CENTER.—The Secretary shall enter into or modify contracts with utilization and quality control peer review organizations

under which such organizations shall serve as referral centers for second opinions required under this section.

"(2) REFERRAL OF PATIENT.—The organization shall maintain in a list of physicians qualified to provide a second opinion and shall advise the patient as to which physicians are participating physicians (within the meaning of section 1842(h)) and which physicians have agreed to accept assignment for second opinions. If the patient seeking the second opinion so requests, the organization shall refer such patient to a physician of the appropriate specialty for purposes of providing the second opinion.

"(3) FREEDOM OF CHOICE OF PATIENT TO CHOOSE PHYSICIAN.—Subject to paragraph (4), the patient may choose any physician of the proper specialty to provide the second opinion.

"(4) PHYSICIANS PROHIBITED FROM PROVIDING SECOND OPINION.—For purposes of this section, a second opinion may not be provided by a physician who is affiliated with, or has any direct or indirect common financial interest with, the physician who rendered the first opinion that the procedure was necessary.9

"(5) FORWARDING OF RELEVANT MEDICAL RECORD.—Each such organization shall, if the patient seeking the second opinion so requests, obtain the relevant medical records from the physician who rendered the first opinion that the procedure was necessary, and provide the relevant information to the physician selected by the patient to render the second opinion in such form so as not to identify the physician who rendered the first opinion.

"(6) USE OF OTHER ENTITIES AS REFERRAL CENTERS.—(A) If no utilization and quality control peer review organization is available to perform the functions described in this subsection, the Secretary may enter into an agreement with a State or local agency or appropriate private entity to perform such functions.

"(B) If a State is utilizing an entity other than a utilization and quality control peer review organization to provide referrals for second opinions for purposes of title XIX, the Secretary may enter into an agreement under this section with such entity (rather than with a utilization and quality control peer review organization) to perform the functions described in this section if the Secretary determines that such arrangement would be more cost effective and would adequately protect the patients receiving benefits under this title.

"(C) If the Secretary determines that a utilization and quality control peer review organization is not able to perform the referral services described in this subsection in a manner that adequately protects patients, the Secretary may enter into an agreement with a State or local agency or appropriate private entity to perform such functions.

"(d) EXCEPTIONS TO REQUIREMENT.—The requirements of this section shall not apply—

"(1) if delay in providing the surgical procedure would result in a risk to the patient;

"(2) if no physician is available (within such reasonable limits as the Secretary shall determine by regulation) who is (A) an appropriate specialist, and (B) a participating physician or a physician who has agreed to accept assignment for the second opinion; or

"(3) the surgical procedure is to be performed on a patient who is a member of a health maintenance organization or competitive medical plan having a risk-sharing contract with the Secretary under section 1876(g).

"(e) DUTIES OF PHYSICIANS, HOSPITALS, AND AMBULATORY SURGICAL CENTERS TO NOTIFY PATIENTS.—

"(1) NOTICE.—Any physician, before performing a surgical procedure which requires a second opinion pursuant to this section, and any hospital or ambulatory surgical center, before a patient is furnished services at the hospital or center in connection with the performance of such a procedure, shall inform the patient in writing of the necessity of obtaining a second opinion, and make available to the patient, or to the entity performing referral services under subsection (c) if so requested by the patient, any medical records available to such physician, hospital, or center that are necessary in order for the patient to obtain such second opinion.

"(2) SANCTIONS.—(A) In the case of any physician, hospital, or ambulatory surgical center which fails to notify a patient of the need to obtain a second opinion or fails to make available medical records, as required under paragraph (1), the Secretary may—

"(i) impose a civil monetary penalty and assessment, in the same manner as such penalties are authorized under section 1128A(a), or

"(ii) in the case of a second or subsequent failure, bar the physician, hospital, or ambulatory surgical center from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d),

or both. No payment may be made under this title with respect to any item or service furnished by a physician, hospital, or ambulatory surgical center during the period when it is barred from participation in the program under this title pursuant to this subsection.

"(B) The Secretary may not bar a physician, hospital, or ambulatory surgical center pursuant to subparagraph (A) if such physician, hospital, or ambulatory surgical center is a sole source of essential services in a community.

"(C) The Secretary shall take into account access of beneficiaries to physicians' services, hospital services, and other surgical facility services for which payment may be made under this title in determining whether to bar a physician, hospital, or ambulatory surgical center from participation pursuant to subparagraph (A).

"(D) In any case where payment under this title is denied by reason of this section, and a physician, hospital, or ambulatory surgical center failed to notify the patient as required by paragraph (1), the Secretary shall, out of any civil monetary penalty or assessment collected from such physician, hospital, or ambulatory surgical center pursuant to this subsection, make a payment to the patient in the nature of restitution for amounts paid by such patient to such physician, hospital, or ambulatory surgical center which otherwise would have been paid under this title.

"(f) NOTICE BY SECRETARY.—

"(1) NOTICE TO PHYSICIANS, HOSPITALS, AND AMBULATORY SURGICAL CENTERS.—The Secretary shall notify all physicians, all hospitals having agreements under section 1866, and all ambulatory surgical centers having an agreement with the Secretary described in section 1832(a)(2)(F) of the requirements of this section. The notice shall include the applicable list of surgical procedures to which such requirements apply, and a description of the penalties for failure to notify a patient concerning such requirements.

"(2) NOTICE TO BENEFICIARIES.—The Secretary shall provide for periodic notice to all beneficiaries under this title of the requirements of this section, including the applicable list of the surgical procedures to which such requirements apply and information about the availability of the referral services described in this section. The Secretary shall make the applicable lists and information about referral services available at district and branch offices of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.".

(b) WAIVER OF DEDUCTIBLE AND COPAYMENTS.—

(1) DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 13951(b)) is amended by striking out "and" before "(4)", and by inserting before the period at the end of the first sentence the following: ", and (5) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion)".

(2) COPAYMENTS.—(A) Section 1833(a)(1) of such Act (42 U.S.C. 13951(a)(1)) is amended by striking out "and" before "(F)", and by adding at the end thereof the following' "and (G) with respect to items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services".

"(B) Section 1833(a)(2)(A) of such Act (42 U.S.C. 13951(a)(2)(A)) is amended by inserting ", items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion)," after "(other than durable medical equipment)".

(C) Section 1833(a)(2)(D) of such Act (42 U.S.C. 13951(a)(2)(D)) is amended by striking out "or to a provider having an agreement under section 1866" and inserting in lieu thereof "to a provider having an agreement under section 1866, or for tests furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion)".

(c) CONFORMING AMENDMENTS.—

(1) EXCLUSIONS FROM COVERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395g(a)), as amended by section 107(a) of this Act, is amended—

(A) by striking out "or" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; or"; and

(C) by adding at the end thereof the following new paragraph:

"(16) furnished in connection with a surgical procedure if a second opinion is required under section 1890 but is not obtained.".

(2) PROVIDER AGREEMENTS.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking out "and" at the end of subparagraph (G);

(B) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof ", and"; and

(C) by inserting after subparagraph (H) the following new subparagraph:

"(I) to notify beneficiaries under this title for whom surgery is to be performed of the need to obtain a second opinion if such surgery is a procedure listed pursuant to section 1890.".

(3) FUNCTIONS OF PEER REVIEW ORGANIZATIONS.—Section 1154(a) of such Act (42 U.S.C. 1395c-3(a)) is amended by adding at the end thereof the following new paragraph:

"(12) The organization shall perform the referral functions for second opinions described in section 1890(c).".

(d) EFFECTIVE DATES.—(1) The amendments made by subsection (a) shall apply to items and services furnished on or after the first day of the first month which begins more than 6 months after the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall promulgate final regulations necessary to implement the amendments made by this section within 6 months after the date of the enactment of this Act.

(e) INTERIM LIST.—(1) If the Secretary of Health and Human Services has not established a list or lists of surgical procedures requiring second opinions, as required under section 1890 of the Social Security Act, within 6 months after the date of the enactment of this Act, then the following list shall be in effect for purposes of such section:

Coronary artery bypass.
Cardiac pacemaker implantation.
Cataract surgery.
Gall bladder surgery.
Prostate surgery.
Knee surgery.
Hysterectomy.
Back surgery.
hernia repair.
Hemorrhoidectomy.

(2) The list in paragraph (1) shall remain in effect until such time as the Secretary establishes a new list for the applicable State or area pursuant to section 1890.

(f) STUDY.—The Secretary of Health and Human Services shall conduct a study of the results of the amendments made by this section. Such study shall include any changes in utilization of surgical procedures, changes in nonconfirmation rates of second opinions, and outcomes in cases where surgery is not done after a second opinion failed to confirm the necessity of the surgical procedure. The Secretary shall report the results of the study to the Congress within 30 months after the date of the enactment of this Act.

SEC. 132. CHANGING MEDICARE APPEAL RIGHTS.

(a) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new sentence: "Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item.".

(b) REVIEW OF PART B DETERMINATIONS.—(1) Section 1869 of such Act (42 U.S.C. 1395ff) is further amended—

(A) by inserting "or part B" in subsection (a) after "amount of benefits under part A",

(B) by inserting "or part B" in subsection (b)(1)(C) after "part A", and

(C) by amending paragraph (2) of subsection (b) to read as follows:

"(2) Notwithstanding paragraph (1)(C), in the case of a claim arising—

"(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or

"(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.".

(2) Section 1842(b)(3)(C) of such Act (42 U.S.C. 1395u(b)(3)(C)) is amended by striking out "$100 or more" and inserting in lieu thereof "at least $100, but not more than $500".

(3) Section 1879(d) of such Act (42 U.S.C. 1395pp(d)) is amended by striking out "section 1869(b)" and all that follows through "part B)" and inserting in lieu thereof "sections 1869(b) and 1842(b)(3)(C) (as may be applicable)".

(c) EFFECTIVE DATES.—(1) The amendment made by subsection (a) takes effect on the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall apply to claims submitted on or after October 1, 1985.

SEC. 133. EXTENSION OF ON LOK WAIVER.

(a) CONTINUED APPROVAL.—

(1) MEDICARE WAIVERS.—Notwithstanding any limitations contained in section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services shall continue approval of the risk-sharing application (described in section 603(c)(1) of Public Law 98-21) for waivers of certain requirements of title XVIII of the Social Security Act after the end of the period described in that section.

(2) MEDICAID WAIVERS.—Notwithstanding any limitations contained in section 1115 of the Social Security Act, the Secretary shall approve any application of the Department of Health Services, State of California, for a waiver of requirements of title XIX of such Act in order to continue carrying out the demonstration project referred to in section 603(c)(2) of Public Law 98-21 after the end of the period described in that section.

(b) TERMS, CONDITIONS, AND PERIOD OF APPROVAL.—The Secretary's approval of an application (or renewal of an application) under this section—

(1) shall be on the same terms and conditions as applied with respect to the corresponding application under section 603(c) of Public Law 98-21 as of July 1, 1985, except that requirements relating to collection and evaluation of information for demonstration purposes (and not for operational purposes) shall not apply; and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with the terms and conditions described in paragraph (1).

PART C—TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

SEC. 141. GUIDELINES FOR LONG-TERM HEALTH CARE POLICIES.

(a) ESTABLISHMENT OF TASK FORCE.—The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a Task Force on Long-Term Health Care Policies (hereinafter in this section referred to as the "Task Force"). The Task Force shall be established not later than 60 days after the date of the enactment of this Act and in consultation with the National Association of Insurance Commissioners.

(b) COMPOSITION OF TASK FORCE.—The Task Force shall be composed of 18 members, which shall include—

(1) to members representing the National Association of Insurance Commissioners,

(2) three members representing Federal and State agencies with responsibilities relating to health or the elderly,

(3) three members representing private insurers,

(4) three members from organizations representing consumers or the elderly, and

(5) three members from organizations representing providers of long-term health care services.

The Secretary shall designate a member of the Task Force as chair.

(c) DEVELOPMENT OF GUIDELINES.—The Task Force shall develop guidelines for long-term health care policies, including guidelines designed—

(1) to limit marketing and agent abuse for those policies,

(2) to assure the dissemination of such information to consumers as is necessary to permit informed choice in purchasing the policies and to reduce the purchase of unnecessary or duplicative coverage,

(3) to assure that benefits provided under the policies are reasonable in relationship to premiums charged, and

(4) to promote the development and availability of long-term health care policies which meet these guidelines.

(d) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Task Force shall report to the Secretary and Congress respecting—

(1) the guidelines developed under subsection (c), including an explanation of the reasons for their selection, and

(2) such recommendations for additional activities respecting long-term health care policies as the Task Force finds appropriate.

The Secretary, in cooperation with the National Association of Insurance Commissioners, shall provide for the dissemination of the report to each of the States.

(e) ANNUAL REPORT OF SECRETARY.—The Secretary shall annually report to Congress on—

(1) actions taken by the States to implement the guidelines developed under this section,

(2) recommendations for the development of additional guidelines (or modification of proposed guidelines), and

(3) recommendations for legislative and administrative action needed to respond to issues raised by the Task Force or to improve consumer protection with respect to long-term health care policies.

(f) LONG-TERM HEALTH CARE POLICY DEFINED.—In this section, the term "long-term health care policy" means an insurance policy, or similar health benefits plan, which is designed for or marketed as providing (or making payments for) health care services (such as nursing home care and home health care) or related services (which may include home and community-based services), or both, over and extended period of time.

TITLE II—MEDICAID PROGRAM

SEC. 201. SERVICES FOR PREGNANT WOMEN.

(a) EXPANDED COVERAGE.—Section 1905(n)(1) of the Social Security Act (42 U.S.C. 1396d(n)(1)) is amended—

(1) by striking out "; or" at the end of subparagraph (A) and inserting in lieu thereof a comma,

(2) by striking out "; and" at the end of subparagraph (B) and inserting in lieu thereof ", or", and

(3) by adding after subparagraph (B) the following new subparagraph:

"(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and".

(b) OPTIONAL EXPANSION OF PREGNANCY-RELATED SERVICES.—Section 1902(a)(10) is amended, in the matter after subparagraph (D) thereof—

(1) by striking out "and" before "(IV)" and inserting in lieu thereof a comma, and

(2) by inserting before the semicolon the following: ", and (V) the making available to all pregnant women covered under the plan of services relating to pregnancy (including pre-natal, delivery, and post-partum services) or to any other condition which may complicate pregnancy shall not, by reason of subparagraph (B), require the making available of these services, or the making available of such services of the same amount, duration, and scope, to any other individuals".

(c) POST-PARTUM ELIGIBILITY FOR PREGNANT WOMEN.—Section 1902(e) of such Act (42 U.S.C. 1396b(e)) is amended by adding at the end the following new paragraph:

"(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall be deemed to remain pregnant, for purposes of the provision of all pregnancy-related and post-partum medical assistance under the plan, until the end of the 60-day period beginning on the last day of her pregnancy.".

(d) EFFECTIVE DATES.—

(1) EXPANDED COVERAGE.—(A) The amendments made by subsection (a) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after October 1, 1985, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(2) OPTIONAL SERVICES.—The amendments made by subsection (b) shall take effect on October 1, 1985.

(3) CONTINUED COVERAGE.—The amendment made by subsection (c) shall apply to medical assistance furnished to a woman on or after October 1, 1985.

SEC. 202. MODIFICATIONS OF HOME AND COMMUNITY-BASED WAIVER UNDER SECTION 1915(c).

(a) EXPLICIT INCLUSION OF CERTAIN VOCATIONAL, PREVOCATIONAL, AND EDUCATIONAL SERVICES.—Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended by adding at the end the following new paragraph:

"(5) For purposes of paragraph (4)(B), the term 'habilitation services', with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

"(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings, and

"(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services, but

"(C) does not include—

"(i) special education and related services (as defined in sections 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency, and

"(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).".

(b) PERMITTING HOSPITAL LEVEL OF CARE FOR CERTAIN PARTICIPANTS.—(1) Paragraph (1) of such section is amended by inserting "or but for the provision of such services the individuals would continue to receive inpatient hospital services because they are dependent on ventilator support the cost of which is reimbursed under the State plan" before the period at the end.

(2) Paragraph (2)(C) of such section is amended—

(A) by inserting "hospital or" after "provided in a", and

(B) by inserting "inpatient hospital services or" after "the provision of".

(c) PROHIBITING IMPOSITION OF CERTAIN REGULATORY LIMITS.—Such section, as amended by subsection (a), is further amended—

(1) in paragraph (2)(D), by inserting "100 percent of" after "does not exceed", and

(2) by adding at the end the following new paragraph:

"(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.".

(d) COMPUTATION OF EXPENDITURES FOR CERTAIN DISABLED PATIENTS.—Such section, as amended by subsection (c), is further amended by adding at the end the following new paragraph:

"(7) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under

the State plan separately from the expenditure for other individuals who are inpatients of those facilities.".

(e) PERMITTING FLEXIBILITY IN ESTABLISHING MAINTENANCE INCOME STANDARDS.—Paragraph (3) of such section is amended by adding at the end the following new sentence: "A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.".

(f) EFFECTIVE DATES.—

(1) HABILITATION SERVICES AND HOSPITALIZED PATIENTS.—The amendments made by subsections (a) and (b) are effective for services furnished on or after October 1, 1985.

(2) PROHIBITION OF REGULATORY LIMITS AND TREATMENT OF CERTAIN PHYSICALLY DISABLED INDIVIDUALS.—The amendments made by subsections (c) and (d) shall apply to applications for waivers filed before, on, or after, the date of the enactment of this Act and for services furnished on or after August 13, 1981.

(3) INCOME STANDARDS.—The amendment made by subsection (e) shall apply to waivers approved on or after the date of the enactment of this Act.

(g) TASK FORCE ON ALTERNATIVE CARE FOR TECHNOLOGY-DEPENDENT, CHRONICALLY ILL CHILDREN.—(1) The Secretary of Health and Human Services, within six months after the date of the enactment of this Act, shall establish a task force concerning alternatives to institutional care for technology-dependent children (as defined in paragraph (5)).

(2) The task force shall include representatives of Federal and State agencies with responsibilities relating to child health, health insurers, large employers (including those that self-insure for health care costs), providers of health care to technology-dependent children, and parents of technology-dependent children.

(3) The task force shall—

(A) identify barriers that prevent the provisions of appropriate care in a home or community-setting to meet the special needs of technology-dependent children, and

(B) recommend changes in the provision and financing of health care in private and public health care programs (including appropriate joint public-private initiatives) so as to provide home and community-based alternatives to the institutionalization of technology-dependent children.

(4) The task force shall make a final report to the Secretary and to the Congress on its activities not later than two years after the date of the enactment of this Act.

(5) In this subsection, the term "technology-dependent child" means a child who has a chronic illness which makes the child dependent upon the continuing use of medical care technology (such as a ventilator).

SEC. 203. OPTIONAL HOSPICE BENEFITS.

(a) COVERAGE OF HOSPICE CARE AS AN OPTIONAL MEDICAID BENEFIT.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) by striking out "and" at the end of paragraph (17),

(B) by redesignating paragraph (18) as paragraph (19), and

(C) by inserting after paragraph (17) the following new paragraph:

"(18) hospice care (as defined in subsection (o)); and"; and

(2) by adding at the end the following new subsection:

"(o)(1) The term 'hospice care' means the care described in section 1861(dd)(1) furnished by a public, or private nonprofit, hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to receive hospice care instead of certain other benefits (described in section 1812(d)(2)) under the plan.

"(2) An individual's voluntary election under this subsection—

"(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2),

"(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish, and

"(C) may be revoked at any time without a showing of cause of may be modified so as to change the hospice program with respect to which a previous election was made.".

(b) ELIGIBILITY.—

(1) LIMITATION TO TERMINALLY ILL INDIVIDUALS.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by section 201(b) of this Act, is further amended, in the matter following subparagraph (D), by striking out "and" before "(V)" and by inserting before the semicolon the following: ", and (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals".

(2) HIGHER INCOME STANDARD PERMITTED.—Section 1902(a)(10)(A)(ii) of such Act (42 U.S.C. 1396a(a)(10)(a)(ii)) is amended—

(A) by striking out "or" at the end of subclause (V),

(B) by striking out the semicolon at the end of subclause (VI) and inserting in lieu thereof ", or", and

(C) by adding at the end the folowing new subclause:

"(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);".

(c) PAYMENT FOR HOSPICE CARE.—

(1) USE OF MEDICARE RATES.—Section 1902(a)(13) of such Act (42 U.S.C. 1396a(a)(13)) is amended—

(A) by striking out "and" at the end of subparagraph (B),

(B) by redesignating subparagraph (C) as subparagraph (D), and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C) for payment for hospice care in the same amounts, and using the same methodology, as used under part A of title XVIII; and".

(2) LIMITATION ON COPAYMENTS.—Subsections (a)(2) and (b)(2) of section 1916 of the Social Security Act (42 U.S.C. 1396o) are each amended—

(A) by striking out "or" at the end of subparagraph (C),

(B) by striking out "; and" at the end of subparagraph (D) and inserting in lieu thereof ", or", and

(C) by adding at the end the following new subparagraph:

"(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and".

(d) CONFORMING AMENDMENTS.—

(1) Section 1902(j) of such act (42 U.S.C. 1396a(j)) is amended by striking out "(18)" and inserting in lieu thereof "(19)".

(2) Section 1902(a)(10)(C)(iv) of such Act (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking out "through (17)" and inserting in lieu thereof "through (18)".

(e) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance provided for hospice care furnished on or after October 1, 1985.

SEC. 204. MEDICAID PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS OF HOSPITALS.

(a) MEDICAID PAYMENT METHODOLOGY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 203(c)(1) of this Act, is further amended—

(1) in paragraph (13) of subsection (a)—

(A) by striking out "and" at the end of subparagraph (C),

(B) by redesignating subparagraph (D) as subparagraph (E), and

(C) by inserting after subparagraph (C) the following new subparagraph:

"(D) for payment to hospitals for direct medical education costs in amounts determined in accordance with subsection (h); and"; and

(2) by inserting before subsection (i) the following new subsection:

"(h) PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS.—

"(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Instead of any amounts that are otherwise payable under a State plan with respect to the costs of hospitals for direct medical education costs, the State shall provide for payments to hospitals for such costs in accordance with paragraph (3) of this subsection.

"(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each residency year beginning on or after July 1, 1985, as follows:

"(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, based on data from the most recent available audited cost report of the hospital, the average amount recognized as reasonable under title XVIII for direct medical education costs of the hospital for each full-time-equivalent resident.

"(B) UPDATING UP THROUGH JUNE 1985.—The Secretary shall update each average amount determined under subparagraph (A) through June 1985 by the percentage increase in the consumer price index from the midpoint of the cost reporting periods used under subparagraph (A) to the end of December 1984.

"(C) AMOUNT FOR RESIDENCY YEAR BEGINNING JULY 1, 1985.—For the residency year beginning July 1, 1985, the approved FTE resident amount for each hospital is equal to the amount determined under paragraph (B) for that hospital updated, to the end of December 1985, by projecting the estimated percentage increase in the consumer price index during the 12-month period ending with December 1985.

"(D) AMOUNT FOR SUBSEQUENT RESIDENCY YEARS.—

"(i) GENERAL RULE.—Except as provided in clause (ii), for each residency year beginning after July 1, 1985, the approved FTE resident amount for each hospital is equal to the amount determined under this paragraph for the previous residency year updated by projecting the estimated percentage change in the consumer price index during the 12-month period ending with December of that residency year, with appropriate adjustments to reflect previous under- or over-estimations under this paragraph in the projected percentage change in the consumer price index.

"(ii) LIMITATION ON APPROVED FTE RESIDENT AMOUNTS.—The approved FTE resident amount for a hospital for a residency year may not exceed—

"(I) for the residency year beginning on July 1, 1986, 175 percent,

"(II) for the residency year beginning on July 1, 1987, 150 percent, and

"(III) for residency years beginning on or after July 1, 1988, 125 percent,

of the median amounts determined under clause (i) for all the hospitals in the United States for that residency year.

"(E) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not have an approved medical residency training program and was not participating in the program under title XVIII for a cost reporting period ending before 1985, the Secretary shall provide, for the first such period for which it has such a residency training program and is participating under this title, for such approved FTE resident amount as the Secretary determines to be appropriate, based on comparable approved FTE resident amounts for similar programs of similar hospitals located in similar areas.

"(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

"(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after October 1, 1985, is equal to the product of—

"(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

"(ii) the hospital's medicaid patient load (as defined in subparagraph (C)) for that period.

"(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term 'aggregate approved amount' means, for a hospital cost reporting period, the sum of the products, for each residency year occurring during the cost reporting period, of—

"(i) the fraction of that residency year that occurs during the period,

"(ii) the hospital's approved FTE resident amount (determined under paragraph (2)) for that residency year, and

"(iii) the number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that year.

"(C) MEDICAID PATIENT LOAD.—As used in subparagraoh (A), the term 'medicaid patient load' means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the reporting period which are attributable to patients with respect to whom payment may be made under the State plan approved under this part.

"(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

"(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

"(B) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that time so spent by a resident under an approved medical residency training program in an outpatient clinic, facility of a health maintenance organization, or other ambulatory setting shall be counted toward the determination of full-time equivalency.

"(C) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a residency year with a hospital or simultaneously with more than one hospital.

"(D) WEIGHTING FACTORS FOR PRIMARY CARE AND OTHER SPECIALTIES.—Subject to subparagraphs (E) and (F), such rules shall provide, in calculating the number of full-time-equivalent residents in approved residency program for residency years beginning on or after July 1, 1987, for the application of a weighting factor for residents determined in accordance with the following table:

"For the residency year beginning in—	The weighting factor for each—		
	(i) primary care resident is—	(ii) other resident—	
		(I) during the initial residency period is—	(II) during any other period is—
1987.....	1.10	.90	.75
1988.....	1.20	.80	.50
1989 or later.....	1.30	.70	.50

"(E) ALTERNATIVE COMPUTATIONS OF FULL-TIME EQUIVALENTS.—For residency years beginning on or after July 1, 1989, the Secretary may change the weighting factors described in the table in subparagraph (D) or may establish alternative methods for calculating the number of full-time equivalent residents, based on recommendations of the Physician Payment Review Commission (established under section 1845).

"(F) SPECIAL RULES FOR FOREIGN MEDICAL GRADUATES.—

"(i) REQUIRED TO PASS FMGEMS EXAMINATION.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident for a residency year beginning on or after July 1, 1986, unless the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)) before the beginning of the residency year.

"(ii) TRANSITION FOR CURRENT FMGS.—For the residency year beginning on July 1, 1986, in the case of a foreign medical graduate who—

"(I) has served as a resident before that year and is serving as a resident during that year, but

"(II) has not passed the FMGEMS examination before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

"(iii) TREATMENT OF CERTAIN ECFMG-CERTIFIED INDIVIDUALS.—For purposes of this subparagraph, the Secretary may provide for an individual to be treated as having passed the FMGEMS examination if the individual is unable to take that examination because the individual has previously received certification from the Educational Commission for Foreign Medical Graduates.

"(5) DEFINITIONS.—As used in this subsection:

"(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved medical residency training program' means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes

formal postgraduate training programs in geriatric medicine approved by the Secretary.

"(B) CONSUMER PRICE INDEX.—As used in this paragraph, the term 'consumer price index' refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

"(C) DIRECT MEDICAL EDUCATION COSTS.—The term 'direct medical education costs' means direct costs of approved educational activities for approved medical residency training programs.

"(D) FOREIGN MEDICAL GRADUATE.—The term 'foreign medical graduate' means an individual who is a graduate of a medical school not accredited by a body or bodies approved for this purpose by the Secretary of Education (regardless of whether the school of medicine is in the United States).

"(E) FMGEMS EXAMINATION.—The term 'FMGEMS examination' means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose.

"(F) INITIAL RESIDENCY PERIOD.—The term 'initial residency period' means, in the case of a resident, the minimum number of years of formal training necessary to satisfy the requirements (as specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education) for initial board eligibility in the particular specialty for which the resident is training; except that—

"(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of residency of more than five years for any individual, and

"(ii) a period, of not more than two years, during which an individual is a resident in the field of geriatric medicine or the field of public health and preventive health shall not be counted towards the initial residency period.

"(G) PRIMARY CARE RESIDENT.—The term 'primary care resident' means an individual during the individual's first three years of postgraduate medical training in the field of internal medicine, pediatrics, or family medicine, but does not include such an individual who—

"(i) has been accepted for postgraduate medical training in a field other than internal medicine, pediatrics, family medicine, geriatric medicine, or public health and preventive medicine, and

"(ii) is receiving such training as part of the initial training for that field.

Such term also includes an individual during up to two years of postgraduate medical training in the field of geriatric medicine or the field of public health and preventive medicine.

"(H) RESIDENCY YEAR.—The term 'residency year' means a 12-month period beginning on July 1.

"(I) RESIDENT.—The term 'resident' includes an intern or other participant in an approved medical residency training program.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after July 1, 1986, under State plans approved under title XIX of the Social Security Act; except that such amendments shall not apply to such payments for costs incurred (or services rendered) before that date.

(d) REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary of Health and and Human Services shall report to Congress, not later than December 31, 1986, on whether section 1902(h) of the Social Security Act should be revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

SEC. 205. TREATMENT OF POTENTIAL PAYMENTS FROM MEDICAID QUALIFYING TRUSTS.

(a) AMOUNTS TREATED AS BEING AVAILABLE FROM GRANTOR TRUSTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

"(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17), is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term 'grantor' means the individual referred to in paragraph (2).

"(2) For purposes of this subsection, a 'medicaid qualifying trust' is a trust, or similar legal device, established by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

"(3) This subsection shall apply without regard to—

"(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this title, or

"(B) whether or not the discretion described in paragraph (2) is actually exercised.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical assistance furnished on or after the first day of the second month beginning after the date of the enactment of this Act.

SEC. 206. WRITTEN STANDARDS FOR PROVISION OF ORGAN TRANSPLANTS.

(a) DENIAL OF FEDERAL PAYMENTS FOR ORGAN TRANSPLANTS UNLESS PROVIDED UNDER WRITTEN STANDARDS.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396(i)) is amended by inserting before paragraph (2) the following new paragraph:

"(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

"(A) similarly situated individuals are treated alike, and

"(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance furnished on or after July 1, 1986.

SEC. 207. DEEMED RESIDENCE FOR OUT-OF-STATE ADOPTIVE AND FOSTER CARE PLACEMENTS.

(a) GENEAL RULE.—Section 1902(b) of the Social Security Act (42 U.S.C. 1396a(b)) is amended by adding at the end the following:

"For purposes of this title, any individual receiving aid or assistance under any plan of a State approved under part E of title IV shall be deemed to be receiving such aid or assistance from the State in which the individual actually resides."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act.

SEC. 208 EXTENSION OF MMIS DEADLINE.

(a) NEW DEADLINE.—Section 1903(r)(1)(B) of the Social Security Act (42 U.S.C. 1396b(r)(1)(B)) is amended by striking out "the earlier of" and all that follows through the end of subparagraph (B) and inserting in lieu thereof "September 30, 1985.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment under section 1930(a) of the Social Security Act for calendar quarters beginning on or after October 1, 1982.

SEC. 209. EXTENSION OF CERTAIN WAIVER PROJECT.

(a) CONTINUED APPROVAL.—Notwithstanding any limitations contained in section 1115 of the Social Security Act but subject to subsection (b) of this section, the Secretary of Health and Human Services, upon application, shall continue approval of demonstration project number 11-P-97473/6-06 ("Modifications under the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged"), previously approved under that section, until December 31, 1988.

(b) TERMS AND CONDITIONS.—The Secretary's continued approval of the project under subsection (a)—

(1) shall be on the same terms and conditions as applied to the project as of the date of the enactment of this Act, and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with such terms and conditions.

SEC. 210. REPORT ON ADJUSTMENT IN MEDICAID PAYMENTS FOR HOSPITALS SERVING DISPROPORTIONATE NUMBERS OF LOW INCOME PATIENTS.

The Secretary of Health and Human Resources shall transmit to Congress, not later than July 1, 1986, a report that—

(1) describes the methodology used by States under section 1920(a)(13)(A) of the Social Security Act, in their making payments to hospitals, in taking into

account the situation of hospitals that serve a disproportionate number of low income patients with special needs,

(2) identifies each of those hospitals that have had the amount of their payments under that title adjusted under that section, and

(3) for each of those hospitals, describes the proportion of total inpatient-days attributable to low income patients and the proportion of total inpatient days attributable to patients entitled to medical assistance under that title.

SEC. 211. REFERENCE TO PROVISIONS OF LAW PROVIDING COVERAGE UNDER, OR DIRECTLY AFFECTING, THE MEDICAID PROGRAM.

Title XIX of the Social Security Act is amended by adding at the end the following new section:

"REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

"SEC. 1919. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law that make additional individuals eligible for medical asistance under this title, see the following:

"(1) AFDC.—(A) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

"(B) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

"(C) Section 414(g) of this Act (relating to certain individuals participating in work supplementation programs).

"(2) SSI.—Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

"(3) REFUGEE ASSISTANCE.—Section 412(e)(5) of the Immigration and Nationality Act (relating to medical assistance for certain refugees).

"(4) MISCELLANEOUS.—(A) Section 230 of Public Law 93-66 (relating to deeming eligible for medical assistance certain essential persons).

"(B) Section 231 of Public Law 93-66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

"(C) Section 232 of Public Law 93-66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

"(D) Section 13(c) of Public Law 93-233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

"(E) Section 503 of Public Law 94-566 (popularly known as the 'Pickle Amendment', relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

"(b) ADDITIONAL STATE PLAN REQUIREMENTS.—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

"(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs).

"(2) Section 212(a) of Public Law 93-66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).".

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Purpose and Summary

The purpose of the Committee bill is twofold: to achieve the expenditure reductions assumed by the First Concurrent Resolution on the Budget for Fiscal Year 1986, H. Con. Res. 152, and to make improvements in the Medicare and Medicaid programs.

On July 24, 1985, the House adopted H. Res. 231, which provided that the House-passed Budget Resolution for Fiscal Year 1986, H. Con. Res. 152, would be considered to be adopted by the Congress for purposes of the Congressional Budget Act as it applies to the House of Representatives. H. Con. Res. 152 contained reconciliation instructions to the Committee on Energy and Commerce and directed that the Committee take action to achieve the level of expenditure reductions specified in the instructions within 30 calendar days. In order to comply with that directive, the Committee ordered reported these amendments on August 1, 1985. Subsequent to the bill being ordered reported, the House adopted the conference report on S. Con. Res. 32, establishing the First Concurrent Resolution on the Budget—FY 1986.

On July 31, 1985, the Ways and Means Committee ordered reported the Deficit Reduction Amendments of 1985, H.R. 3128 (H. Rep. 99–241, Part I), which contains a number of amendments to the Medicare program. The bill was referred to the Committee on Energy and Commerce for consideration of those parts within its jurisdiction. In lieu of considering H.R. 3128, the Committee ordered reported its own bill, H.R. 3101, as a companion measure to H.R. 3128.

With respect to Medicare, the Committee bill incorporates, without change, a number of provisions previously reported by the Committee on Ways and Means in H.R. 3128 (H. Rep. 99–241, Part I). These provisions relate to the working aged; assistants at cataract surgery; calculation of the Part B premium; payment for hospital-based physicians; occupational therapy services; prosthetic lenses; health maintenance organizations; preadmission certification programs; ESRD networks; and preventive services demonstrations. The Committee bill also includes, with amendments, the provisions reported by the Ways and Means Committee relating to the physician payment review commission; reimbursement of durable medical equipment; and extension of the physician fee freeze.

The Committee bill contains a number of provisions affecting Medicare Part B that were not reported by the Committee on Ways and Means: fee schedules for clinical laboratory services; mandatory second surgical opinions; vision care; Part B appeals; and extension of the On Lok waiver.

Finally, the Committee bill contains a number of Medicaid reform proposals, including an infant mortality reduction initiative; revision of the home and community-based services waiver authority; optional hospice coverage; revision of payments for direct medical education; treatment of assets in certain Medicaid qualifying trusts; and standards for the coverage of organ transplants.

The net savings achieved by the Committee bill, according to the Congressional Budget Office, total $2,459 billion over the fiscal years 1986–1988.

With respect to the Medicare provisions, the test of the Committee bill is organized as a companion bill to H.R. 3128 (H. Rep. 99–241), as reported by the Committee on Ways and Means. The amendments contained in title I, Part A of the Committee bill relate primarily to Part B of the Medicare program. They are divided into two groups: those provisions which overlap with those contained in H.R. 3128 (group 1); and those provisions which do not overlap with those contained in H.R. 3128 (group 2). The amendments contained in title I, Part B of the Committee bill, which relate primarily to Parts A and B of the Medicare program, are grouped in a similar fashion.

Background and Need for the Legislation

TITLE I—MEDICARE PROGRAM

Provisions Relating Primarily to Part B of the Medicare Program

Extension of physician fee freeze for nonparticipating physicians and improvements in the Participating Physician Program (sec. 101)

Medicare pays for physician services on the basis of medicare-determined "reasonable charges". Reasonable charges are the lowest of: (1) a physician's actual billed charge; (2) the charge customarily made by an individual physician; or (3) the prevailing charge limit, derived from a statistical analysis of charges made by all physicians for services in a geographic area. The customary and prevailing charge screens are generally updated annually. Increases in the prevailing charge levels are limited by an economic index that reflects general inflation and changes in physicians' office practice costs.

Under the Deficit Reduction Act of 1984 (P.L. 98–369) the medicare customary and prevailing charges for all physicians' services provided during the 15-month period beginning July 1, 1984 are frozen at the levels that applied for the 12-month period ending June 30, 1984. The actual charges which physicians are permitted to bill beneficiaries are also frozen during the 15-month period, at the levels that were charged during April–June 1984.

The Deficit Reduction Act also instituted a medicare participating physician and suppliers program. Participating physicians and suppliers voluntarily agree to accept assignment on all medicare claims for the 12-month period beginning on October 1 of a year. Nonparticipating physicians and suppliers can decide on a claim-by-claim basis whether or not to accept assignment.

Beneficiaries who receive services from participating physicians and suppliers know in advance of receiving services that all the services provided to them will be taken on an assigned basis, and that they will not incur out-of-pocket costs, other than the deductible and coinsurance amounts mandated by statute.

The carriers responsible for paying medicare claims are required to monitor nonparticipating physicians' actual charges during the 15-month freeze. Physicians who knowingly and willfully bill beneficiaries in excess of what they charged during April–June 1984

can be subject to civil monetary penalties and/or exclusion from participation in medicare.

The Committee bill would extend the current freeze for most physicians who do not choose to be participating physicians. However, it would not extend the freeze for physicians who sign participation agreements for next year. In addition, it would provide a partial update in next year's fees for those physicians who are currently participating (and those who are currently taking assignment all of the time), but who do not agree to participate after October 1, 1985.

On October 1, 1985, any physician who agrees to participate for the year beginning October 1, 1985, either by extending an existing agreement or entering into a new one, would receive an update in customary and prevailing charges. The same prevailing charge screens would apply to all participating physicians, regardless of their participation status at the present time. This is intended to provide an incentive for physicians to participate, and reflects the priority the Committee attaches to increasing participation rates.

With regard to customary charge updates, physicians who are participating for a second year may realize some advantage over physicians who are signing agreements for the first time. The updated customary charges of physicians who continue to participate would reflect their actual charges made from April 1984 through March 1985, which were not subject to any freeze. The updated customary charges of new participating physicians would be based on their actual charges for the same period, but these physicians' actual charges were frozen at April–June 1984 levels.

The prevailing charge limits on which reasonable charge determinations for participating physicians would be based would reflect the updated customary charges of all physicians. Customary charges of nonparticipating physicians would be calculated (based on actual charges made from April 1984 through March 1985, although they were frozen at April–June 1984 levels) but these customary charges would be used solely for the purpose of computing new prevailing charges for participating physicians; they would not be used to determine Medicare payment for nonparticipating physicians.

The Committee bill would maintain the participating physician program as a permanent feature of the medicare program and would attempt to enhance it in several ways. Beginning on October 1, 1986, the prevailing charge screen applicable to nonparticipating physicians each year would (except in the case noted below) be the same as the one that applied to participating physicians the preceeding year. Thus, a permanent differential would be established between the prevailing charges applicable to participating and nonparticipating physicians.

The Committee bill would extend the current freeze on customary, prevailing, and actual charges for any physician who did not agree to be a participating physician for the year beginning October 1, 1985 and who neither was a participating physician on September 30, 1985 nor chose to accept assignment, in the absence of a participating agreement, for all of his Medicare services during the period October 1, 1984 through September 30, 1985. Therefore, for physicians who chose not to take assignment for some or all of

their services during the current freeze period and who choose not to sign a participation agreement effective October 1, 1985, the current payment rules and restrictions would continue in effect, without change, for an additional twelve months. The carriers could continue to monitor the charges actually billed to beneficiaries by these physicians. Any increases in their actual charges would not be recognized in computing their customary charges on October 1, 1986 or October 1, 1987 and any such increases, if made knowingly and willfully, could subject these physicians to civil money penalties or exclusion from the program.

The Committee bill would treat differently those physicians who signed participating agreements for the current period, but who do not extend those agreements after October 1, 1985. A limitation on charges, rather than a freeze, would be applied to such physicians. A similar limitation would also be applied to physicians who have not signed participation agreements for either period but who, nonetheless, actually took assignment 100 percent of the time during the period from October 1, 1984 through September 30, 1985. These two groups of physicians would receive an increase in their prevailing charges on October 1, 1985, equal to one-half of the increase they would have received if they has signed a participation agreement affective October 1, 1985. They will also receive an increase in their customary charges on October 1, 1985, again equal to one-half of what the increase would have been had they signed a participation agreement. For physicians with current participating agreements, this would recognize one-half of the difference between their customary charges on July 1, 1983 and their actual charges during the period from April 1984 through March 1985. (These actual charges were not subject to the current freeze because the physician had signed a participation agreement.) For physicians without a current participation agreement, this amount to a recognition of one-half of the difference between their customary charges on July 1, 1983 and their actual charges during the period April 1984 through June 1984.

The actual charges for these two groups of physicians would be subject to a freeze and to monitoring by the carriers. For physicians who do not have a current participation agreement, but who are now taking assignment 100 percent of the time, their current actual charges are frozen at the level they were in the period from April 1984 through June 1984. This would continue to be the case after October 1, 1985. Physicians who currently have participation agreements are not now subject to a freeze on their actual charges. Beginning October 1, 1985, they would be subject to a freeze on their actual charges (if they did not renew their participation agreements). The freeze level would be established by allowing their actual charges for the period from April 1984 through June 1984 to be increased by one-half of the amount of the increase in their actual charges between June 1984 and April 1985. As is the case with other nonparticipating physicians, these actual charges would be monitored by the carriers. Charges in excess of these freeze levels would not be recognized by the carriers in computing customary charges for October 1, 1986 and October 1, 1987. (The period of the freeze—October 1, 1985 to September 30, 1986—overlaps with the data base period for both these annual updates.)

As noted above, beginning on October 1, 1986 and thereafter, the prevailing charge screens for nonparticipating physicians, would generally lag one year behind the prevailing charge screens for participating physicians. This would not be the case, however, for physicians who were participating physicians in the immediately preceding period and for those who actually took assignment in all cases during the immediately preceding period even if they did not sign a participation agreement. For these physicians, he prevailing charge screens for participating physicians during the immediately preceding year and the prevailing charge screens for participating physicians in the current year. That is to say, the prevailing charge screens would lag by half of the amount of other nonparticipating physicians.

In response to complaints by participating physicians regarding billing and claims processing problems they encountered during the first year of the participating program, the bill would provide for the development of professional relations staff at the carriers dedicated exclusively to addressing the billing and other problems of participating physicians and suppliers.

The Committee intends that the Secretary devote sufficient funds to the carriers for maintenance of their toll-free telephone lines so that they are useful to beneficiaries seeking information about participating physicians and suppliers. Sufficient resources should also be devoted to ensure that participating physicians and suppliers enjoy the benefit of the carriers' direct lines for the electronic receipt of claims.

The bill eliminates the statutory requirement in the Deficit Reduction Act for publication of the Physician Assignment Rate List (PARL), which lists the name, address, specialty and previous year's assignment rate for all physicians and suppliers, regardless of their participation status. The PARL is said to be confusing to beneficiaries and little used.

The Committee intends that the directories of participating physicians and suppliers be organized so as to be meaningful and useful to beneficiaries. For example, if, in especially large metropolitan areas, local medical markets can be identified, these should serve as the basis for organizing the directories.

The bill would require that the appropriate area directories be sent to all participating physicians in an area to facilitate and encourage the development of referral networks among participating physicians and suppliers. The Committee also expects that copies of the appropriate area directories of participating physicians and suppliers be sent to the local and national offices of each Member of Congress to facilitate responses to beneficiaries' inquiries for information on the participating physicians and suppliers in their area.

The bill includes a provision which would require that, for all unassigned claims, the Explanation of Medicare Benefits (EOMB) provided to all Medicare beneficiaries include a message reminding beneficiaries of the participating physician and supplier program, and providing them with the toll-free number for information in their area. The message would also remind beneficiaries of the limitation on the charges participating physicians and suppliers may impose; that is, that they cannot charge beneficiaries extra-billing

amounts. The bill specifies that this provision be implemented by April 1, 1986. This gives the Secretary ample time to test messages, if necessary, to insure that they convey information to beneficiaries in a meaningful and appropriate fashion.

The provision in the Deficit Reduction Act for the transfer in fiscal year 1985 of $15 million from the Federal Supplementary Medical Insurance trust fund to the carriers would be extended to apply to fiscal year 1986 (in the same amount), for the continued administration of the physician fee freeze and participating physician and supplier program.

The fee freeze and participating physicians provisions would apply to services furnished on or after October 1, 1985.

Physician Payment Review Commission and development of relative value scale (sec. 102)

The Committee bill would establish a new advisory body whose purpose would be to review Medicare policies regarding payment for physician services and to evaluate possible changes in such policies. No such group exists under current legislation.

The Director of the Congressional Office of Technology Assessment would appoint an 11-member Physician Payment Review Commission. The mission and duties of the Commission would be to make recommendations to the Congress by February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services, and changes in the methodology for determining and making payment for medicare physicians' services and other items and services under part B.

It is the Committee's intent that the Commission examine improvements that can be made in the near term in the existing reasonable charge structure of medicare, as well as analyze major structural reforms that Congress, over time, might make in the payment methodology. The Committee has an immediate interest in having the Commission consider and develop options concerning reductions in existing specialty and geographic differentials. The Committee also has an immediate interest in the Commission reviewing the relative charge levels for various services, with a view towards identifying those which seem to be out-of-line, taking into account the appropriate costs of providing such services. The Committee seeks the Commission's assistance in making the current payment methodology more equitable and more effective in providing cost-effective, higher quality health care and is interested in the Commission's recommendations for selective and specific reductions or increases in change levels, as appropriate to achieve these goals.

In making any recommendations for modifications or reforms in the current payment methodology, the Commission would assess the likely impact of such payments on utilization and quality, on physician participation in the participation program, and on beneficiary access to physicians' services. The Commission would also make recommendations on ways to increase participation and assignment rates.

The Commission would also be given assignments related to other provisions in the Committee bill. The Commission would be asked to identify procedures in addition to cataract surgery for

which payments for assistants-at-surgery should be eliminated, to make recommendations as to those procedures for which second opinions should be required, and to evaluate the weighting factors used in making medicaid payments for graduate medical education.

The bill would require the Commission to review and comment on the HHS study of physician DRGs and the OTA study of fee schedules, and to make recommendations regarding the advisability and feasibility of structural reforms.

The Committee bill would also require the Secretary, with advice from the Commission, to develop a relative value scale (RVS). The Committee expects that the Commission and the Secretary will consider such factors as the various imput costs of furnished particular physicians' services, as well as existing charge levels. Analysis of the imput costs of all physicians' services would not necessarily be required, but the Committee expects that services and items which account for a high volume among the medicare population, or which account for a large share of medicare physician spending, or for which the charges seem "out-of-line" would be targeted for careful analysis. The Committee also expects the Secretary to examine whether existing procedure codes can be consolidated, whether services associated with a particular procedure can be bundled, and whether other forms of aggregation or simplification are appropriate.

In developing the RVS, the Secretary would be directed to consider the OTA study of fee schedules and the Commission's recommendations. The Secretary would be required to report to Congress on the development of the RVS not later than April 1, 1987, with a view towards possible implementation by October 1, 1987. The Committee expects that the report would include an analysis of the likely impact of the RVS on participation and assignment, access to care, quality, cost and utilization.

The provision would be effective October 1, 1985.

Part B premium (sec. 103)

The Secretary is presently required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for people enrolled in the Supplementary Medical Insurance (part B) portion of medicare. A temporary provision of law requires that, for 1986 and 1987, the premium amount for enrollees aged 65 and over be calculated so as to produce total premium revenues equal to 25 percent of the estimated total Part B expenditures for such enrollees.

Under current law, this provision would expire after 1987 and premiums for 1988 could not exceed the premiums for 1987 by more than the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

The Committee bill would extend for one additional year (1988) the existing temporary provision maintaining premiums at 25 percent of estimated program costs. If there were no Social Security cost-of-living adjustment in any year this provision is in effect, the Medicare premium would not be increased for that year.

The provision would be effective on enactment.

Determination of inherent reasonableness of charges and customary charges for certain former hospital-compensated physicians (sec. 104)

(a) Inherent reasonableness

Payment for items and services under part B is generally made on the basis of reasonable charges. The reasonable charge is defined as the lowest of the actual charge, the customary charge and the prevailing charge for a given item or service. An economic index limits increases in prevailing charges for physicians' services. The law provides for some flexibility in the determination of reasonable charges, and regulations specify criteria that may be used in making these determinations. The regulations at 42 CFR 405.502(a)(7) allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service . . . in judging whether the charge is inherently reasonable."

The Committee bill's provision relating to inherent reasonableness would require the Secretary to publish regulations which (1) specifiy the factors to be used in determining the cases (of particular items and services) for which the application for the reasonable charge methodology results in reasonable charges that, by reason of their grossly excessive or grossly deficient amounts, are not inherently reasonable, and (2) specify, in such cases, the factors that will be considered in establishing reasonable charges that are realistic and equitable. The requirement for promulgation of such regulations is intended to prevent arbitrary application of inherent reasonableness and to expose to public comment the process and criteria to be used.

In identifying the kinds of cases to which the inherent reasonableness criteria shall be applied, the Secretary should consider situtations such as those in which charges (1) are substantially in excess of acquisition or production costs; (2) reflect a market dominated by one or few providers or suppliers; (3) do not reflect changes in technology that significantly alter the cost of furnishing the service; (4) are substantially higher for medicare patients than for others; or (5) reflect unrealistically low payment amounts, such as those that resulted from the application of the CRCC methodology for hospital-based physicians.

In establishing a reasonable charge that is realistic and equitable, the Secretary could specify that such factors as charges in other localities and manufacturers' wholesale lists or suggested retail prices would be considered.

The purpose of this provision is to provide for adjustments in cases in which the charges determined by the reasonable charge methodology are not inherently reasonable. Reductions in the excessive markups on prothestic lenses, as recently reported by the Committee on Aging would be an appropriate application of this provision. The Committee does not intend that this provision be used as a means to alter the basic methodology for determining reasonable charges, or to challenge such practices as recognizing specialty and geographic differentials in payment. This provision would be effective upon enactment.

(b) Hospital-compensated physicians

With the elimination of combined-billing arrangements, effective October 1, 1983, carriers established compensation-related customary charges (CRCCs) for certain hospital-compensated physicians, The CRCC provision was intended to be transitional; hospital-compensated physicians (those who received compensation from the hospital for services furnished to hospital patients) would have received customary charge updates on July 1, 1984 based on their actual charges had it not been for the freeze on medicare customary and prevailing charges for physicians; services, instituted by the Deficit Reduction Act.

Under the Committee bill, hospital-compensated physicians who, between October 31, 1982 and January 31, 1985, terminated the arrangements under which they were compensated by a hospital for part B services furnished to its patients, would receive customary charges based on their actual charges.

On October 1, 1985, participating physicians who are covered by this provision would have their customary charges updated based on actual charges made during the 12-month period ending March 31, 1985. This is the same base period used to update the customary charges of other participating physicians. Nonparticipating physicians covered by this provision would have their customary charges updated on October 1, 1985 based on actual charges during the same base period, but their customary charges would be deflated to approximate levels based on 1982 actual charges, on which other nonparticipating physicians' customary charges would be based under the bill.

The bill specifies that the customary charges of the nonparticipating physicians would be deflated by multiplying them by .83. This factor is equal to the ratio of the physicians' services component of the CPI (all urban consumers, seasonally-adjusted) for June 1982, to that same CPI component for September 1984. (These dates are the midpoints of the base periods for the July 1, 1984 and the October 1, 1985 and the October 1, 1986 fee screen updates, respectively.)

On October 1, 1986, participating and nonparticipating physicians covered by this provision would be treated the same as all other participating and nonparticipating physicians.

This provision would be applicable with respect to services furnished on or after October 1, 1985.

Occupational therapy services (sec. 105)

Occupational therapy is a medically prescribed treatment concerned with improving or restoring functions of an individual that has been impaired by illness or injury or, when functions have been permanently lost or reduced by illness or injury, with improving the individual's ability to perform those tasks required for independent functioning.

Medically necessary occupational therapy services are covered under part A of medicare when provided as a part of covered inpatient or post-hospital extended care services in a skilled nursing facility or as part of home health services or hospice care.

Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency or when incident to a physican's service.

The Committee bill would extend reimbursement under part B of medicare for occupational therapy services. Occupational therapy would be covered when provided in a skilled nursing facility (when part A coverage is exhausted), in a clinic, or a rehabilitation agency. Payment for services in these settings would be made on a reasonable cost basis.

In addition, occupational therapy services would be covered when furnished in a therapist's office or a beneficiary's home, if the therapist met licensing and other standards prescribed by the Secretary. No more than $500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary. Payment for these settings would be based on 80% of reasonable charges.

Generally speaking, the bill would make medicare coverage of occupational therapy services comparable to the existing coverage of physical therapy services.

The Committee believes that the value of occupational therapy services to beneficiaries merits a modest expansion of the program. Further, the Committee finds that such services have the potential to reduce and avoid the need for institutional care, while enabling the beneficiary to function more independently.

The bill would be effective for items or services furnished on or after October 1, 1985.

Payment for durable medical equipment (sec. 106)

Durable medical equipment (DME) is a covered part B benefit reimbursable on the basis of reasonable charges. In the past, medicare payment for DME was made for both rented and purchased items, depending on the beneficiary's decision to either rent or purchase. As a result, the majority of DME was rented, even when purchase would have been more economical.

Beginning February 1, 1985, the Secretary implemented three methods for reimbursing DME under medicare: lease-purchase, lump sum purchase or rental charges. Equipment costing less than $120 is considered inexpensive equipment and payment is made only on the basis of purchase. For equipment costing more than $120, the carrier must determine which method is cost-effective based on the beneficiary's expected need for the equipment (as indicated on the physician's prescription) and reimburse accordingly. Used equipment that is purchased and that meets certain standards is reimbursed at 100%, rather than 80% of the reasonable charge (applicable copayment amounts are waived).

The beneficiary still has the option to rent or purchase DME. However, payment is made pursuant to the carrier's determination as to which method is cost-effective.

The prevailing and customary amounts for DME (both rental and purchase) were previously updated annually on July 1, but beginning with 1985 will be updated on October 1. The amount by which the prevailing charges increase is not limited by any economic index.

It has been recognized that the prevailing and customary charge amounts for DME reimbursed on a purchase basis are not well es-

tablished in certain areas. As a result, the Secretary has instructed the carriers to use other methods when there are insufficient actual charge data for determining the customary or the prevailing charge in the locality.

Suppliers are able to sign participating agreements with the Secretary whereby they agree to accept assignment for all medicare claims for a year. Nonparticipating suppliers can choose on a claim by claim basis whether or not to accept assignment.

The Committee bill would make several changes in current law:

(a) The bill would freeze both customary and prevailing charges for rented DME and for purchases of oxygen supplies during FY 1986, at the same level at which they were computed for the 15-month period beginning July 1, 1984.

(b) Medicare payments for durable medical equipment provided on a rental basis and for purchases of oxygen supplies would only be made on the basis of mandatory assignment, i.e., the supplier would be required to accept medicare's allowable charge as his or her full charge and could collect from the beneficiary no more than the applicable deductible and coinsurance.

(c) For DME items furnished on or after October 1, 1986, the bill would limit the increase in prevailing charges, for both rentals and purchases, to no more than the Consumer Price Index for all urban consumers.

The Committee intends that the Secretary, in applying the CPI index to the prevailing charges for purchased equipment for FY 1987, provide for an adjustment where it appears that the indexed charges for a particular item would result in significantly inappropriate amounts, in accordance with her authority under the bill's provisions relating to "inherent reasonableness" of charges.

Paragraph (a) would be effective with respect to items or supplies furnished on or after October 1, 1985.

Paragraph (b) would be effective with respect to items or supplies furnished on or after January 1, 1986.

Paragraph (c) would be effective with respect to items or supplies furnished on or after October 1, 1986.

Payment for assistants at surgery for certain cataract operations and other operations (sec. 107)

Currently, medicare covers assistants at surgery during routine cataract operations. Their services are considered reasonable and necessary if it is the generally accepted practice among ophthalmologists in the local community to use an assistant at surgery. Some medicare carriers restrict coverage of assistants at surgery to cases where medical necessity is established.

The Committee bill would deny medicare payment for assistants at surgery for routine cataract operations. For cases in which complicating medical conditions exist which warrant the use of an assistant, the Secretary would be required to establish procedures by which the primary surgeon could request prior approval from the PRO for use of an assistant.

The assistant at surgery (or someone on his or her behalf) would be prohibited from billing medicare or the beneficiary for services which did not receive a prior approval. In addition, the primary surgeon (or someone on his or her behalf) would be prohibited from

including charges for the assistant in his or her bill for services. The proposal would give the Secretary the authority to impose civil monetary penalties or assessments, or exclusion for up to five years from the medicare program, or both, in order to enforce this provision and to ensure that beneficiaries are protected additional out-of-pocket costs.

The Committee reviewed the findings of the Office of the Inspector General, HHS, which stated that the use of an assistant at surgery was not medically necessary in most situations. This finding was based on the practices of many primary ophthalmic surgeons who do not use such assistants. In addition, several medicare carriers currently restrict coverage of assistants at surgery, and there has been no indication that this has an adverse effect on patients.

The Secretary would be required, after consultation with the Physician Payment Review Commission established under the bill, to develop and report to Congress by April 1, 1986, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary. The Secretary would be required to include in this report recommendations regarding the circumstances under which prior approval from an appropriate entity for the use of an assistant at surgery would be justified for these other surgical procedures, along with a process for implementing such prior approval.

This provision would be effective with respect to services performed on or after October 1, 1985.

Limitation on Medicare payment for post-cataract surgery patients (sec. 108)

Medicare part B currently pays for certain prosthetic lenses, if determined to be medically necessary by the physician, i.e., cataract contact lenses and eyeglasses. Generally, part B carriers are authorized to replace prosthetic lenses without a physician's order in cases of loss or irreparable damage and when supported by physician's order in cases of a change in the patient's condition. Currently, there are no uniform limits on the number of replacements for which medicare will provide reimbursement.

Physicians can bill medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physician's services.

The Committee bill would limit medicare reimbursement with respect to replacement of lost or damaged prosthetic lenses as follows:

(1) cataract eyeglasses: one replacement each year;

(2) cataract contact lenses: one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. The Secretary would determine the "years" over which these limitations will apply.

The Secretary would be required to provide for separate payment amount determinations for the prosthetic lenses and for the related professional services, and to apply inherent reasonableness guidelines, in accordance with a separate provision of the bill, in determining reasonableness of charges for prosthetic lenses.

The Committee accepted the recommendations of the General Accounting Office which suggested the need for uniform limits for the replacement of such lenses. The Committee believes that these limits will ensure that benefits are uniformly applied.

The Committee intends, however, that the Secretary would not apply these limits where replacement of such lenses is the result of either a change in the patient's condition (and is supported by a physician's order) or of the natural wearing out of a lens.

The bill would be effective for items or services furnished on or after October 1, 1985.

Demonstration of preventive health services under Medicare (sec. 109)

Medicare does not generally provide coverage for preventive health services.

Under the Committee bill, the Secretary of HHS would be rquired to fund at least five demonstrations, under the auspices of schools of public health, to determine whether and how it would be cost-effective to include preventive services as a medicare benefit.

Services to be made available to beneficiaries would include health screenings, health risk appraisals, immunizations, counseling and instruction on such matters as diet and nutrition, reduction of stress, exercise, sleep regulation, prevention of alcohol and drug abuse and mental health disorders, self-care, and smoking reduction.

Within three years, the Secretary would be required to submit a report to Congress describing the demonstrations in progress. Within five years the Secretary would be required to submit a final report that would evaluate the costs and benefits of providing such services and recommend whether specific preventive services should be included as a medicare benefit.

The provision would be effective on October 1, 1985.

Payment for clinical labratory services (sec. 111)

Prior to July 1, 1984, clinical laboratory tests furnished to ambulatory patients were reimbursed under Medicare on the basis of reasonable charges, (for services furnished by an independent laboratory or physician) or on the basis of the lower of reasonable cost or reasonable charges, (for services furnished by a hospital). Section 2303 of the Deficit Reduction Act of 1984 reformed Medicare reimbursement for such services, effective July 1, 1984. Payment is now made on the basis of fee schedules established by the Medicare carriers. The initial fee schedules were established at a percentage of the prevailing charge screens that would have become effective on July 1, 1984. Subsequent fee schedules are to be established by adjusting the initial fee schedules annually for changes in the Consumer Price Index. Currently, separate fee schedules are derived for, and applied to, the various Medicare carrier service areas or localities, but the statute calls for a national fee schedule to be implemented in 1987.

Available data indicate that the current, local fee schedules vary significantly from one carrier area or locality to another, without any consistent pattern or rationale. A given area or locality may have a very high fee schedule, relative to other areas and localities,

for one test, but an average or relatively low fee schedule for other tests. These variations in the fee schedules reflect the prior be explainable with reference to differences in the costs of performing the tests or regional variations in the cost of living. The magnitude and apparently haphazard nature of these variations suggest that some of these tests are currently being reimbursed excessive amounts under Medicare and that it will be difficult to implement a national fee schedule in a equitable manner by 1987.

The Committee bill would establish ceilings on the maximum amounts that Medicare would pay under the local fee schedules. Beginning January 1, 1986, a separate Medicare payment ceiling would be set for each test that is subject to the fee schedule provision. The ceiling for a given test would be set at 115% of the median fee established for that test under the existing local fee schedules. Thus, a different ceiling would be set for each test, based on the existing fee schedules for that particular test.

Separate ceilings would be established for tests performed by a hospital laboratory for outpatients of such hospital, since these tests are subject to different fee schedules from those applicable to other laboratories. These ceilings would then be applied nationally to all tests reimbursed under Medicare.

As a result of the Committee's bill, a clinical diagnostic laboratory test would be reimbursed at the lowest of the actual charge, the fee schedule established for the carrier service area, or the ceiling established under this provision.

Under current law, the annual update for inflation is made on July 1, and the schedules were increased on July 1, 1985. The Committee bill would change the date of this adjustment to October 1, beginning in 1986, in order to ease the administration of this provision. The October 1, 1986 adjustment would take into account the change in the Consumer Price Index for a 15-month period, rather than a 12-month period. The statutory date for implementing a national fee schedule would also be changed from July 1, 1987 to October 1, 1987.

On October 1, 1986, the payment ceiling applicable to the local fee schedules would be revised from 115% of the median to 110% of the median fee schedule for each test. This ceiling would remain in effect until a national fee schedule was adopted.

The Committee is cognizant of concerns expressed about the lack of quality control standards for laboratories located in physicians offices. Hospital laboratories and independent laboratories are subject to standards designed to protect the safety of patients and assure the competence of the laboratory, and to periodic reviews for compliance with such standards. Physician office laboratories, however, are not subject to similar requirements. The Committee believes that it would be appropriate for physician office laboratories to be subject to such standards, but recognizes that this may be difficult, not only because physician office laboratories are quite numerous, but also because they vary significantly in scope or range of tests performed. The Committee bill requires the Secretary of Health and Human Services to report to the Congress, within 12 months of enactment of the bill, with recommendations regarding the standards that might be established for physician office laboratories. The Committee expects the Secretary to exam-

ine both the type of standards that would be needed to assure the safety and competence of such laboratories and the feasibility of reviewing such laboratories for compliance. In undertaking this review, the Secretary should consider the variety of physician office laboratories and the need for different standards and compliance procedures for different types of laboratories.

In the course of reforming the payment methodology for clinical laboratory services last year in the Deficit Reduction Act, the Congress also provided for the payment of a nominal fee when independent or hospital laboratories must collect a specimen by venipuncture or catheterization. The Conferees intended that this fee be paid in addition to a trip fee, if such a trip fee was previously approved in situations in which the laboratory had to send a trained technician to a nursing home or to a patient's home. (If the technician drew specimens from more than one patient of a nursing home, the lab would qualify for a specimen collection fee for each such patient, but for only one trip fee.) However, the Committee has been advised that some carriers are denying payment for a specimen collection fee, on the grounds that it is included in the previously approved trip fee and that separate payment would be duplicative.

The Committee has also been advised that there is great variation among the carriers with respect to payments for trip fees. The Committee expects the Health Care Financing Administration to review the carriers' policies to make sure they conform to the Deficit Reduction Act, as well as to achieve greater equity and consistency. The Committee recognizes that this issue is difficult to resolve, given the present variations in local fee schedules noted above, and that a totally satisfactory resolution may not be possible until a national fee schedule is implemented. However, the Committee believes that HCFA should provide clearer guidance to the carriers as promptly as possible.

Vision care (sec. 112)

Under current law, Medicare will reimburse for eye examination services furnished by an opthalmologist, or by another doctor of medicine or osteopathy, to a patient with a complaint or symptom of eye disease or injury. Medicare will reimburse for examination services furnished by an optometrist, however, only if the services are related to the condition of aphakia. Medicare will not pay for eyeglasses or for eye examinations for the purpose of prescribing, fitting or changing eyeglasses (except in the case of prosthetic lenses for aphakic patients). Payment is denied for all refractive procedures, even if performed in connection with the diagnosis or treatment of an eye disease or injury or for the purpose of prescribing prosthetic lenses.

The Committee has held two hearings at which these coverage rules were examined. On both occasions, the Committee was advised that these rules are impinging on beneficiaries' access to needed eye care. Many beneficiaries are either foregoing covered eye care or are paying out-of-pocket for eye care services furnished by optometrists, because they do not have ready access to an ophthalmologist and because the present rules are too difficult to understand.

The Committee bill would allow Medicare payments for eye examination services furnished by optometrists, subject to two prerequisites. The service must be one which is currently covered by medicare if furnished by a doctor of medicine or osteopathy and it must be within the services the optometrist is authorized to perform under the licensure laws of the State in which the service is performed.

The bill would not expand or change the current coverage and reimbursement rules in any other manner. To be reimbursed, the services would, as under current law, have to be reasonable and necessary for the diagnosis of an injury or disease. The current, generally applicable rules for reasonable charge reimbursement would be used to determine payments to optometrists. It is the Committee's expectation that the medicare carriers, with guidance from the Health Care Financing Administration, would use information regarding payments they make for optometrists' services under their own health plans, or other appropriate information, to establish the initial customary and prevailing charge screens.

This provision would become effective with respect to services furnished on or after April 1, 1986.

Provisions Relating to Parts A and B of the Medicare Program

Extenson of working aged provisions (sec. 121)

The Age Discrimination in Employment Act (ADEA) requires employers of 20 or more people to offer employees and their spouses age 65 through 69 the same health insurance coverage they offer to their younger employees and under the same conditions.

If the older employee chooses the employer's plan, medicare becomes the secondary payor if the employer plan does not pay full benefits.

If the older employee chooses not to participate in the employer's plan, medicare will be the primary payor. The employer is prohibited from offering a health plan designed to supplement medicare, (i.e. fill in medicare's deductible and coinsurance).

Currently, ADEA applies only to persons between the ages of 40 and 70. The Committee bill would make several changes in current law:

(a) The bill would extend the health insurance requirement of ADEA to persons over the age of 69, thereby removing the upper age limit, and would make corresponding changes in medicare law. The change would apply both to employees and employee's spouses over age 69.

(b) ADEA would be amended to provide that the group health insurance requirement be exempted from the age limits.

(c) The bill would make conforming amendments regarding special enrollment periods and the effective date of enrollment.

The changes made by paragraph (a) would apply to items or services furnished on or after January 1, 1986.

The effective date of paragraph (b) would be January 1, 1986.

The effective date of paragraph (c) would be January 1, 1986, with certain exceptions.

Provisions relating to health maintenance organizations and competitive medical plans (sec. 122)

(a) Financial responsibility for patients hospitalized on the effective date of an enrollment or disenrollment

Under the current law it is unclear who is responsible for payment when a medicare beneficiary is an inpatient of a hospital under the prospective payment system on the effective date of his/her TEFRA HMO/CMP enrollment. A similiar problem exists for disenrollment. (A TEFRA HMO/CMP is a health maintenance organization or competitive medical plan with a risk contract under Section 1876 of the Social Security Act, authorized under the Tax Equity and Fiscal Responsibility Act of 1982.)

Under the Committee bill, a TEFRA HMO/CMP would not be financially responsible for reimbursing covered inpatient stays beginning before the effective date of the beneficiary's enrollment in the TEFRA HMO/CMP. Medicare would reimburse for the inpatient stay, if otherwise covered, as if the beneficiary were not enrolled in a TEFRA HMO/CMP. The TEFRA HMO/CMP would be responsible for any other services covered under medicare (i.e., all services except the inpatient stay, such as physician services provided to the patient during the inpatient stay) and any additional or supplemental services which would otherwise be due an enrollee, effective with the date of his/her enrollment in the TEFRA HMO/CMP. Medicare would make its normal monthly capitation payment to the TEFRA HMO/CMP beginning with the effective date of the enrollment, in addition to reimbursing for the inpatient stay. The enrollee would be responsible for premiums or other payments due to the TEFRA HMO/CMP effective with the effective date of enrollment.

Under the bill, if the enrollee was an inpatient in a PPS hospital on the effective date of his/her disenrollment from the TEFRA HMO/CMP, the TEFRA HMO/CMP would be responsible for reimbursing for the full inpatient stay. Medicare would neither make a monthly capitation payment nor pay for the inpatient stay under the regular medicare program, after the effective date of disenrollment. The TEFRA HMO/CMP would not be responsible for additional or supplemental services to the enrollee, beginning on the effective date of disenrollment. This provision would apply only if the inpatient services were provided, or arranged for by the TEFRA HMO/CMP, or if the services were emergency or urgently needed services. The enrollee would not be responsible for any premium or other payments to the TEFRA HMO/CMP, effective with the month of disenrollment.

The provision would be effective for enrollments and disenrollments effective on or after October 1, 1985.

(b) Disenrollment procedures

Present law specifies the effective date of disenrollment from a TEFRA HMO/CMP to be the first calendar month following a full calendar month after the request is made for termination.

Under the Committee bill, the effective date of a disenrollment would be moved forward by one month. Disenrollments would be effective on the first day of the first month following the month in

which the disenrollment request was made. The provision would require that the beneficiary receive a copy of the disenrollment form and that materials be provided to the beneficiary explaining how long he/she must continue to use the HMO/CMP facilities in order to have the services covered.

The Committee is concerned that medicare enrollees should be able to disenroll from TEFRA HMO/CMP without experiencing long delays. The current law could result in a delay of up to 60 days between the time the beneficiary requests disenrollment and the effective date of disenrollment. As a result of a new computer system, the Health Care Financing Administration can now facilitate faster disenrollment. This provision would ensure that a medicare enrollee would never have to wait more than 30 days before the disenrollment request was effective.

In addition, the Committee is concerned that medicare beneficiaries may believe that filing a request to disenroll means they can immediately use the regular fee-for-service medicare program. This is not the case and the Committee is requiring that information be provided to beneficiaries clearly delineating when they may begin to use the regular medicare benefit.

The provision would be effective for requests for termination of enrollment submitted on or after October 1, 1985.

(c) Review of marketing material

There are no provisions in current law relating to marketing materials.

The Committee bill would require all TEFRA HMO/CMPs to submit all brochures, application forms, and promotional and informational material to the Health Care Financing Administration (HCFA) for approval, at least 45 days before issuance. HCFA would be required to review all these materials. If the HMO/CMP did not hear from the HCFA within the 45-day period, the organization could assume approval.

The Committee is concerned that there have been problems with the HMO demonstrations and with some of the ongoing TEFRA HMO/CMPs regarding their marketing materials. Some marketing materials have been misleading or have not provided complete information to the medicare beneficiaries.

In the proposed regulations implementing the TEFRA HMO/CMP legislation, the Secretary would have required review of marketing materials by HCFA for accuracy and completeness. These provisions were dropped when the final regulations were published.

The Committee is concerned that in several instances marketing material supplied to medicare beneficiaries has been misleading, inaccurate and, in some cases, has provided "incentives" to join, which are prohibited by statute. Considering that the TEFRA HMO/CMP benefit is a new benefit and a substantial departure from the traditional method of obtaining services under the medicare program, the Committee feels that a stringent review of marketing materials should be undertaken to ensure accurate description of both the benefit package available to TEFRA HMO/CMP beneficiaries and the limitations, if any, on the providers whose services they can use as enrollees. The Committee wishes to stress that the marketing material should explain the issue of the "lock-

in" in full to beneficiaries prior to their signing up with the HMO/CMP, so that they are well-informed of the limitations on the providers from whom they may seek services.

The Committee understands that this will create an added burden on the central office of HCFA, but believes that this effort is necessary, at least for the early years of implementation of this benefit, in order to protect the interests of the medicare beneficiaries for whom this program is designed.

The provision would apply to material for distribution on or after November 15, 1985. This provision would not apply to material which has been distributed prior to November 15, 1985.

(d) Prompt publication of the AAPCC

In order to establish the payment amounts to TEFRA HMO/CMPs, the Secretary has developed a measure called the Average Adjusted Per Capital Cost (AAPCC). There are no current law requirements relating to the specific date of publication of the AAPCC.

The Committee bill would require the Secretary to publish the AAPCC no later than September 7 of each year. The Committee believes that the Secretary has been slow in publishing the AAPCC. The Committee believes that both HMO/CMPs and HCFA should have as much time as possible to develop their adjusted community rate and to determine their benefit packages. In order to facilitate this, the Committee is requiring that the AAPCC be published six days after the final promulgation of the prospective payment regulations, required by law to be published September 1.

The provision would apply to determinations of per capita rates of payment for 1987 and subsequent years.

Evaluation of Preadmission and Pre-procedure Certification Programs (sec. 123)

Peer review organizations (PROs), with general responsibility to review quality and utilization for inpatient hospital services, have been directed specifically to reduce the rate of inappropriate admissions. All PROs do preadmission screening on some elective surgery. Four PROs are currently responsible for 100% preadmission review of non-emergency surgery.

PROs currently do not have authority to review outpatient care.

Under the Committee bill, the Secretary of HHS would be required to evaluate the efficacy of PRO programs with 100% preadmission elective surgery review, compared with programs that include less comprehensive review.

The Secretary would be required to evaluate the feasibility of extending the PRO pre-procedure certification activities to outpatient and ambulatory settings. The Secretary would also be required to consider whether other organizations, including medicare carriers, could more effectively conduct such pre-procedure screening.

A report to Congress would be due by December 31, 1986.

Prohibition of administrative merger of renal disease networks with other organizations (sec. 124)

The Secretary is required by statute to establish networks to assure the effective and efficient administration of the end stage

renal disease (ESRD) program under medicare. These networks are responsible for performing functions which include: (1) encouraging the use of the treatment setting most compatible with the successful rehabiliation of the patient; (2) developing criteria and standards relating to the quality and appropriateness of patient care, and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation; and (3) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities.

The Committee bill would prohibit the Secretary from dismantling ESRD networks, or from consolidating their organization and functions with Peer Review Organizations or any other entity, without express statutory authorization.

The provision would be effective on enactment.

Technical corrections (sec. 125)

Current medicare law contains a number of technical errors.

(a) The bill would correct problems with the medicare special enrollment period and the premium penalty forgiveness for the working aged. The bill would correct an anomaly under which certain individuals who are working and covered by an employer group health plan receive only one special enrollment period and others receive more than one.

(b) In addition, it would make it clear that an individual would be eligible for forgiveness of the medicare premium penalty for any period during which he or she was over 65 and covered by an employer group health plan.

The provision requiring a person to meet the eligibility requirements of part A and to have filed for part A would be repealed.

(c) The bill would make certain corrections in spelling, language and indentation.

The changes made by paragraph (a) would apply to the first month that begins more than 90 days after the date of enactment, with certain exceptions.

The changes made by paragraph (b) would apply to months beginning January 1983 as they effect premiums for months beginning with the first month that begins more than 30 days after the date of enactment.

The changes made by paragraph (c) would generally be effective as though they had been included in the public laws that they correct.

Second opinions (sec. 131)

Second opinions regarding the appropriateness of surgery are not currently required under the Medicare program. The Health Care Financing Administration does encourage second opinions and has distributed patient information and educational materials on the advantages of second opinions. If a beneficiary obtains a second opinion, Medicare will currently reimburse for the physician and related services. Payment is based on the normal Medicare payment rules, including the standard beneficiary cost-sharing.

Many employer health plans, Blue Cross and Blue Shield plans, State Medicaid programs and other health insurers have instituted

second opinion programs. Some programs are mandatory—payment for the surgical procedures will be reduced or denied entirely if the patient fails to obtain a second opinion—while others are voluntary and the patient is under no obligation to seek a second opinion. An evaluation of second opinion programs conducted for HCFA by Abt Associates concluded that mandatory programs are far more effective than voluntary programs in reducing unnecessary surgery and reducing health care expenditures. This is due principally to the "sentinel effect" or deterrence that mandatory programs exert on the physician giving the initial opinion to avoid making a questionable recommendation in favor of surgery, knowing that it will be reviewed by another physician.

The Committee believes that a mandatory second surgical opinion program will ensure that Americans served by Medicare receive the health care they need and deserve, while at the same time reducing or eliminating unnecessary surgery and the high costs that go with it. It will enable beneficiaries to make informed decisions regarding the desirability of surgery by giving them with more complete information on the benefits and risks of such surgery. It will enhance the beneficiary's freedom of choice as he or she faces the difficult decision of whether to undergo a surgical procedure.

The Committee bill would institute a mandatory second opinion program for Medicare, to be applied to a selected list of at least ten elective surgical procedures. Medicare payments for these procedures would be denied if the beneficiary did not obtain a second opinion, unless certain exceptions or waivers of the requirement were applicable. The second opinion would not have to confirm the first opinion. The beneficiary could choose to undergo the surgery even if the two opinions disagreed and Medicare would make its normal reimbursement. Medicare would also pay for a third opinion if the first two were not in agreement.

Beneficiaries would not be requried to pay any out-of-pocket expenses for the second opinion, or for a third opinion if the second opinion did not confirm the first. The normal deductible and coinsurance obligations would be waived in both of these instances.

In certain circumstances, the beneficiary would not be required to obtain a second opinion, and Medicare would pay for the surgical procedure in the absence of a second opinion. These are instances in which delay in performing the procedure would result in a risk to the health of the individual beneficiary; instances in which there was no physician reasonably available (within such limits on travel, time of other considerations as the Secretary prescribed in regulations) who both was qualified to give the second opinion and had agreed to accept assignment for the second opinion; or cases in which the beneficiary was enrolled in a HMO or competitive medical plan having a risk-sharing contract under Medicare.

The Secretary of Health and Human Services would be responsible for notifying all beneficiaries periodically about the requirements of this provision, including the elements discussed below designed to assist the beneficiary in satisfying the requirements. In addition, both the physician performing the surgery and the hospital or ambulatory surgical facility at which the surgery was to be

performed would be required to inform the beneficiary in writing of the need for a second opinion prior to the surgery. Failure by the physician, hospital or facility could result in civil money penalties being assessed and, in the case of repeat failures, exclusion from the medicare program. It is the Committee's intention that the beneficiary not suffer the financial consequences, if payment is denied under Medicare because the beneficiary did not obtain a second opinion and the physician or facility failed to notify the beneficiary of the requirement to do so. In this situation, the Secretary is to make restitution to the beneficiary, from the civil money penalty assessed under this authority, for the out-of-pocket expenses of the beneficiary of amounts which would have been paid under Medicare if the second opinion requirement had been met. It is the Committee's expectation that physicians, hospitals and surgical facilities will routinely incorporate the practice of giving notice to beneficiaries about the second opinion requirement into their normal preoperation and admissions procedures.

The Committee bill requires the Secretary to designate at least ten elective surgical procedures for which a second opinion would be required. In selecting procedures for the list, the Secretary is to consider: whether the procedure is one that can generally be postponed, while the beneficiary seeks a second opinion, without creating an undue risk to the beneficiary; whether the procedure is costly or accounts for a high volume procedure for Medicare patients; and whether the procedure entails a considerable degree of judgment as to whether it should be performed and opinions regarding the need for surgery after diverge, compared to other procedures.

The Secretary need not designate the same list of procedures for all areas of the country, and may, instead, vary the list based on local conditions if that would appear to be cost effective and better promote the purposes of this provision. It is the Committee's expectation that the Secretary will consult with physician, professional, and consumer groups in selecting procedures for designation. The bill provides a list of ten procedures that would become subject to the requirements of this provision if the Secretary failed to designate procedures within six months of enactment.

For purposes of this provision, a first opinion is one given by a physician qualified to perform the surgery and a second opinion is one given subsequently by a physician determined by the Secretary to be appropriately qualified to do so. The Secretary would designate, for each procedure on the list for which a second opinion is required, those specialties that are qualified to give second opinions. It is the Committee's expectation that the Secretary will consult widely with physician groups in making such designations.

The Committee bill would also establish a mechanism for assisting beneficiaries in obtaining second opinions. Utilization and quality control peer review organizations or, in some instances, other appropriate agencies, would provide information and assistance to the beneficiaries. This would include maintaining a list of physicians who are qualified to provide second opinions, along with information about which of these physicians had agreed to be participating physicians or had agreed to accept assignment for all second opinions. The beneficiary would be free to choose any qualified

physician for a second opinion, except one who had a financial conflict of interest. If the beneficiary requested assistance from the PRO, the PRO would make a referral to a qualified physician for the second opinion. The PRO, at the beneficiary's request, would also obtain the relevant medical records from the physician who rendered the first opinion (or, if necessary, from the hospital or surgical facility) and transmit them to the physician rendering the second opinion in a manner that did not identify the physician giving the first opinion.

It is the Committee's intent that PROs play an important role in facilitating the second opinion program and that their contracts and level of funding be revised to reflect the role. The PRO's would be expected to continue reviewing cases to make sure that surgical procedures are performed in the proper setting and meet quality and utilization goals, but the PROs should avoid review activities which unnecessarily duplicate the second opinion procedures established under the bill.

The effective date for this provision would be the first day of the first month beginning more than six months after enactment. The purpose for this delay is to allow time for the beneficiaries, physicians, hospitals and other affected groups to receive adequate notice of the erquirements and for the Secretary and the PRO's to take the steps necessary to implement the provision effectively.

The bill would also require the Secretary to conduct a study of the provision and how it is affecting utilization and outcomes, and to report to the Congress within 30 months on the results of the study.

Changing Medicare appeal rights (sec. 132)

Under current law, if an individual disagrees with a decision regarding his or her eligibility for Medicare, the individual is given the opportunity for an appeal to an administrative law judge ("ALJ") and to judicial review of the ALJ's decision. Similarly, if a beneficiary disagrees with a denial, in whole or in part, of a claim submitted under Part A of Medicare, he or she is entitled to a hearing before an administrative law judge, if the amount in controversy is $100 or more. The beneficiary also can seek judicial review of the ALJ's decision, if the amount in controversy is $1000 or more. Similar appeal rights are not available, however, to a beneficiary with respect to claims under Part B of Medicare.

If a beneficiary disagrees with a denial of a claim under Part B, he or she can only obtain a reconsideration by the carrier which denied the claim and, if the amount in controversy is $100 or more, a review by a hearing officer appointed by the carrier which denied the claim. There is no judicial review of the hearing officer's decision.

Part B claims were not accorded the same appeal rights as part A claims at the inception of the Medicare program, because Part B claims were expected to be for substantially smaller amounts than claims under Part A. In addition, Part B claims are far more numerous than Part A claims and could present a substantial workload if judicial review were accorded to all of them. Today, however, Part B claims often involve very substantial amounts and, if denied, entail large out-of-pocket expense for the beneficiary.

Numerous concerns have been expressed by beneficiaries about the fairness and adequacy of this Part B appeals process. Some have expressed the concern that the hearing officers are not properly qualified or are not objective, since many of them are former employees of the carrier, also, their continued service as hearing officers may depend on the carriers' being satisfied with the decisions they render. Other concerns deal with the way hearings are conducted, including the beneficiaries' inability to produce evidence or to challenge the hearing officer's decision rules or his reliance on unidentified experts and consultants.

The Committee bill would attempt to resolve these concerns by establishing an appeals procedure under Part B that is modeled after that available under Part A. Review by an ALJ would be available if the amount in controversey were $500 or more and judicial review would be available if the amount in controversy were $1000 or more.

Hearings under Part A are, in most instances, assigned to administrative law judges working in the Office of Hearings and Appeals of the Social Security Administration. Medicare appeals are very different from the social security complaints they typically hear and may represent a very small and infrequent portion of their workload. Therefore, these ALJ's may not develop the experience and expertise in Medicare appeals that they would if they devoted full-time to those appeals. With the additional workload that would be established under the bill, it is the Committee's expectation that the Department of Health and Human Services will give serious attention to establishing a separate office of hearings and appeals for the Health Care Financing Administration or otherwise creating a group of hearing officers devoted exclusively or predominately to Medicare appeals.

Since the inception of the Medicare program, beneficiaries have been permitted to be represented in their appeals by the providers who furnished the services in question. In April, 1984, however, HCFA issued an intermediary manual instruction prohibiting such representation. The prohibition was based on HCFA's view that provider representation could constitute a conflict with the beneficiaries' own interests.

The Committee has consulted with beneficiary groups and has not identified any serious concerns about conflicts of interest. To the contrary, the beneficiary groups have urged that the right of beneficiaries to be represented by providers be restored, on the grounds that providers will be more knowledgeable about Medicare policies and procedures and will have better access to the information needed to present the beneficiaries' claims.

The Committee bill would restore the right of beneficiaries to be represented by the provider that furnished the service in question, effective on the date of enactment. The Committee notes that this provision applies only to appeals under section 1868 of the Social Security Act, and does not affect the rules currently applicable to other appeal provisions such as those in section 1155 of the Act.

Extension of On Lok waiver (sec. 133)

On Lok Senior Health Services of San Francisco, California, provides acute and long-term care services to approximately 300 frail

elderly Medicare and Medicaid patients, all of whom are certified by the State as needing 24-hour skilled nursing or intermediate care. The organization's purpose is to help the elderly remain out of institutions and in their own homes as long as socially, medically, and economically feasible. Under the terms of Medicare and Medicaid waivers approved by the Secretary pursuant to section 603 (c) of the Social Security Amendments of 1983, P.L. 98–21, On Lok is providing a full range of medical and social services to an exclusively frail elderly population on a prepaid, capitated basis, much like a health maintenance organization. It is the Committee's understanding that On Lok is the only organization in the country to assume full financial risk for the provision of all necessary services to the frail elderly who would otherwise be in nursing homes.

The Medicare and Medicaid waivers now in effect for On Lok expire on September 30, 1986. Preliminary results for the first 18 months of this demonstration indicate that the Medicare and Medicaid costs are about 12% lower for patients enrolled in On Lok than for other frail elderly beneficiaries in that area. In the absence of the waivers, this cost-effective project will terminate for lack of financing, and the population now being served will become more costly for the Federal and State governments. The Committee can see no justification for this result.

The Committee bill therefore directs the Secretary to extend the Medicare waiver now in effect until such time as she finds that On Lok no longer complies with the terms and conditions of the waiver. In addition, if the State submits a proposal to extend the Medicaid waivers for On Lok, the Committee bill directs the Secretary to approve this application as well. The Secretary shall not require On Lok to reapply for waivers.

Since the current waiver already includes an extensive evaluation component, there is no need for further research, and the Committee bill provides that, for purposes of the waiver extension, the Secretary shall not require the collection or evaluation of data for research purposes. The Secretary would, of course, be expected to collect relevant information needed for routine program administrative purposes, as she does with any other provider participating in Medicare on a risk basis. It is the intent of the Committee that, in determining the Medicare capitation rate to On Lok, the Secretary adjust for the permanent homebound status of the frail elderly population that On Lok serves; the current institutional adjustment does not adequately reflect the costs of caring for this particular population.

Task Force on Long-Term Health Care Policies

Task Force on Long-Term Health Care Policies (sec. 141)

Over the years, the Committee has become very much concerned about both the availability and the financing of long term care services. The increase in the Nation's elderly population, as well as the rise in long term care expenditures, have only heightened the Committee's interest in finding solutions to these problems.

One such solution currently receiving some attention is the development of insurance policies for long term care that are privately marketed to individuals or groups. Although few of these long

term care products are now on the market, more are expected to become available in the near future.

To help ensure the evolution of sound private long term care policies and to help foster consumer confidence in them, the Committee believes it is important to develop guidelines that can be used by those involved in the insurance industry as well as consumers that may wish to purchase such policies. As the Committee learned during its July 17, 1985 hearing on this issue, such guidelines are necessary in order to avoid the myriad of problems that accompanied the development of private Medicare supplemental, or "Medi-gap", insurance policies.

In response to this need, the Committee bill includes a section on the development and dissemination of guidelines for private long term care insurance policies. The Committee intends for such guidelines to be voluntary in nature and to supplement rather than replace existing State insurance laws and regulations.

Under the Committee bill, the Secretary is required to establish an eighteen-member Task Force on Long Term Health Care Policies. In so doing, the Secretary also is required to consult with the National Association of Insurance Commissioners (NAIC). The Committee recognizes NAIC's expertise in the insurance field and is aware of its ongoing activities with regard to long term care policies. The Committee has mandated, therefore, that the Secretary consult with NAIC on the composition of the Task Force and that she appoint two NAIC representatives to its membership. NAIC has long been a leader in developing standards and guidelines for the insurance industry; it is the Committee's hope that the Secretary will acknowledge this leadership role in establishing the structure of the Task Force.

The Committee bill specifies other types of organizations and government agencies that must be represented on the Task Force. Among those are Federal and State agencies with responsibilities relating to health or to the elderly. The Committee intends for such representatives to be drawn from State Medicaid agencies, departments of health or welfare, State aging commissions or departments of aging, special task forces, or any other appropriate entities. The legislation also requires that private insurers be represented on the Task Force. The Committee recommends that at least one of these representatives come from an organization which currently is marketing a long term care policy or product. In making this selection, consideration should be given to representatives of non-profit as well as for-profit groups. The Committee also recommends that the Secretary look to national organizations in choosing representatives from associations which act on behalf of consumers or the elderly.

The primary charge to the Task Force is to develop guidelines for long term health care policies. Such guidelines are to be designed to achieve four goals: (1) to assure responsible marketing practices and agent sales; (2) to assure the dissemination of adequate information to allow informed consumer choice and to reduce the purchase of duplicative coverage; (3) to assure a reasonable relationship between premiums charged and benefits provided; and (4) to promote the development and availability of policies that meet the guidelines developed by the Task Force. To the extent time and re-

sources permit, the Task Force may develop guidelines and other proposals which would address additional long term care policy concerns. The Committee expects, however, that the Task Force will address fully the bill's four specified goals before it takes up any other questions.

In developing these guidelines, the Task Force should study the various issues raised during the Committee's consideration of this section of the legislation. For example, in developing guidelines designed to limit market abuse, the Task Force should examine the circumstances under which consumer complaints could be appropriately filed against policy agents. Similarly, for guidelines directed at consumer information activities, the Task Force should look at the appropriateness of policy format including the specification and explanation of policy benefits, exclusions, deductibles, coinsurance requirements, and conditions for cancellation and renewal.

The Committee believes that careful consideration should be given to the development of guidelines concerning the relationship between policy premiums and benefits. This provision is not intended to convey authority to the Task Force to recommend specific loss or risk ratios (either current or target) or specific policy content. Rather, this provision has been included to stress the importance of evaluating the premium/benefit ratio as well as the entire benefit package before any long term care policy is placed on the market. Given the uncertainties and the newness of long term care policies, the Committee believes such evaluations are necessary to instill consumer confidence in this developing market as well as to encourage legitimate product experimentation in the insurance industry. It is the Committee's hope and expectation that the Task Force will be able to devise guidelines which can be used to assist State insurance regulators in designing and in implementing their own evaluation programs.

In addition to the guidelines, the Task Force is responsible for preparing a report which specifies the guidelines it has developed and explains the basis for those guidelines. In its report, the Task Force may also make other recommendations concerning activities that might be appropriately undertaken with respect to the development of long term care policies. Such recommendations may be addressed to governmental agencies as well as to private organizations and public interest groups. The Committee bill requires that the report be provided to both the Congress and to the States (through the assistance of NAIC) within eighteen months of its enactment.

One year after the completion of the report of the Task Force and each year thereafter, the Secretary is required to report to Congress on various issues relating to the work of the Task Force. Such issues include actions taken by the States to implement the guidelines developed by the Task Force; recommendations for the development of additional guidelines or the modification of existing guidelines; recommendations for legislative (either Federal or State) and administrative actions that are needed to respond to the issues raised in the report of the Task Force or in subsequent reports of the Department; and recommendations for actions that are needed to improve consumer protection with respect to long term care policies. In preparing this annual report, the Committee rec-

ommends that the Secretary confer with the members of the Task Force as well as with other individuals (including consumers) and groups (including those representing consumers or the elderly) with expert knowledge about long term care policies.

TITLE II—MEDICAID PROGRAM

Services for pregnant women (sec. 201)

Under current law, States are required to provide Medicaid coverage to all pregnant women who meet the income and resource standards of their Aid to Families with Dependent Children (AFDC) programs, regardless of family composition, except those who are in two-parent families which do not meet the unemployed parent test under Title IV–A of the Social Security Act. States are also required to provide Medicaid coverage to all children born on or after September 30, 1983, up to age 5, in any family that meets AFDC income and resource standards, including those in which the principle earner is not unemployed. Under the general Medicaid "comparability" requirement, the benefits offered to pregnant women eligible under these provisions must be equal in amount, duration, and scope to those offered to other categorically needy beneficiaries.

It is the understanding of the Committee that 18 States currently do not cover pregnant women in poor, two-parent families who meet the State AFDC income and resource standards but do not meet the unemployed parent test: Alabama, Arkansas, Colorado, Idaho, Indiana, Kansas, Kentucky, Louisiana, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Pennsylvania, South Dakota, West Virginia, and Wyoming. All of these States are already required to cover children born into these families on or after September 30, 1983, up to age 5.

Testimony heard by the Subcommittee on Health and Environment makes abundantly clear that, in order to reduce the high rates of infant mortality and morbidity in the United States, this country must improve access to prenatal care by poor pregnant women. In a major study entitled "preventing Low Birthweight," the Committee to Study the Prevention of Low Birthweight, under the aegis of the Institute of Medicine of the National Academy of Sciences, concluded that prenatal care was an essential element in any strategy for reducing the incidence of low birthweight births. Low birthweight, the IOM Committee testified, "is the single most important cause of infant mortality in this country and is a major risk factor for cerebral palsy, mental retardation, seizure disorders, respiratory tract illnesses, and many other serious health problems in children." Prenatal care, the IOM Committee concluded, "reduces low birthweight and is cost effective." The IOM Committee estimated that each dollar spent on prenatal care for high-risk women (including the poor) could save as much as $3.38 on specialized care for low birthweight infants.

Unfortunately, in many States the Medicaid program—the largest source of maternity care funding for low-income women—does not offer comprehensive prenatal care to eligible pregnant women. Many States do not offer such critical services as health education and outreach, vitamins, clinic services, or specialized diagnostic

procedures because they would, under the "comparability rules," be required to offer such services to all categorically needy beneficiaries.

The Committee bill requires that States extend Medicaid eligibility to pregnant women in two-parent families who meet the income and resources requirements of a State's AFDC plan, including those in which neither parent is unemployed for purposes of AFDC-UP. Thus, all pregnant women who meet the income and resources requirements of a State's AFDC plan would be eligible for Medicaid coverage, regardless of their particular family circumstances. A State must therefore extend coverage to any pregnant woman who, on the basis of her income and resources alone, would qualify for AFDC had her child been born and living with her. A State must provide this assistance even if the woman's child, if born, would not qualify for AFDC because neither parent was absent, incapacitated, or dead, and even if neither parent was unemployed within the meaning of Title IV-A of the Social Security Act.

As with the pregnant women described at sections 1905(n)(1)(A) and 1905(n)(1)(B) of the Act, the Committee expects that, in determing the eligibility of a pregnant woman for assistance under the Committee's amendment, States will treat the family, for purposes of determining the size of the assistance unit, as if the child were born and living with the family. Thus, a pregnant woman and her working husband would, under this bill, be treated as an assistance unit of three.

Under the Committee bill, eligibility begins from the date of medical verification of pregnancy. It continues through the pregnancy and, for purposes of pregnancy-related and post-partum care, for 60 days thereafter. The Committee bill clarifies that this post-partum coverage is to be extended to all "qualified pregnant women" described in section 1905(n).

The Committee bill further creates a limited exception to the Medicaid "comparability" requirement that all categorically needy beneficiaries receive services equal in amount, duration, and scope. States would be allowed to make available, to all pregnant women covered under their Medicaid plans, services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy, without making those services available to other categorically needy beneficiaries. The purpose of this provision is to allow the States to enrich their Medicaid benefits for pregnant women without extending these additional benefits to other categorically needy groups; States would still be precluded from offering benefits to pregnant women that are lesser in amount, duration, or scope than those offered to other categorically needy beneficiaries. States choosing to enrich their pregnancy-related benefits would have to do so for all Medicaid-eligible pregnant women.

The Committee bill would permit the States to override existing "comparability" limitations on behalf of pregnant women in two respects. First, States could extend to pregnant women payment for preventive and curative services not now covered under their Medicaid plans. Examples of services which are currently optional under section 1905(a)(9) and (13), and which a number of States do not cover, include health education services (including outreach),

clinic services, nutrition counselling, and vitamins or other over-the-counter medications. The Committee amendment would permit States to cover and pay for these services when provided to pregnant women.

The bill would also permit States, with respect to pregnant women, to relax some of the permissible amount, duration, or scope limitations that they now impose on otherwise covered services. For example, a number of States now limit coverage for hospital care to a certain number of days per year. A State might use its discretion under this measure to permit payment for all medically necessary inpatient care for a pregnant woman during the pregnancy and postpartum periods. Extensive care might be required during pregnancy, for example, to avert preterm labor. Similarly, a number of States limit the number of physician visits to which beneficiaries are entitled in a year. The State may want to end this restriction with respect to pregnant women, some of whom may require much greater physican monitoring if premature delivery is to be avoided.

The provision is effective October 1, 1985, without regard to whether or not the Secretary has issued final implementing regulations. States that always require legislative action in order to change any of the terms of their State Medicaid plans would be given additional time to conform to this requirement; they must comply by the first calendar quarter beginning after the close of the first regular State legislative session beginning after enactment. However, a State that merely requires legislative action to appropriate funds to meet this new requirement, and does not always require legislative action to amend its State plan, would not qualify for a delay in the implementation date of October 1, 1985.

Modifications of home and community-based waivers (sec. 202)

Under current law, the Secretary is authorized, upon application by a State, to grant a waiver allowing Federal Medicaid matching funds to be used to purchase home or community-based services to Medicaid-eligible individuals who are determined to require the level of care provided in a skilled nursing facility (SNF) or an intermediate care facility (ICF), including an intermediate care facility for the mentally retarded (ICF/MR). These "2176" waivers, as they are often referred to, are granted for periods of three years, and are renewable. (Section 2176 of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, created section 1915(c) of the Social Security Act, the source of the Secretary's waiver authority). Home and community-based services that are eligible for Federal matching payments under the waivers include case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care, and such other services as the Secretary may approve, other than room and board. They must be provided pursuant to a written plan of care. In order to receive a waiver, States must satisfy the Secretary that, among other things, the waiver will be budget-neutral. That is, the average annual per capital Medicaid expenditure estimated by the State for individuals receiving home and community-based services under a waiver must not exceed the average per capital Medicaid expenditure the State reasonably esti-

mates would have been made in that fiscal year for these individuals if the waiver had not been granted.

On June 25, 1985, the Subcommittee on Health and the Environment held a hearing on the administration of the "2176" waivers by the Health Care Financing Administration and the Office of Management and Budget, with particular reference to final regulations issued on March 13, 1985, at 50 Fed. Reg. 10013, purporting to implement the current statutory provisions. State officials responsible for Medicaid and long-term care policy testified that these regulations were excessively burdensome, overly restrictive, and inconsistent with Congressional intent. They further testified that, if implemented, these regulations would severely undermine current and future State initiatives to use the waiver authority to offer cost-effective home and community-based alternatives to the low-income frail elderly, mentally retarded, and physically disabled who are at risk of nursing home care.

In the view of the Committee, the Secretary, in issuing the March 13, 1985, regulations, has contravened the intent of Congress in establishing the "2176" waiver authority. The purpose of this authority is to enable the States, at their option, to develop budget-neutral alternatives to institutionalization for individuals eligible for Medicaid who are at risk of nursing home care. The effect of various requirements contained in the March 13 regulations is to require the States to demonstrate that their proposed waiver programs will significantly reduce Medicaid expenditures for this population. While the Committee is of course supportive of responsible efforts to achieve Medicaid savings without impairing the quality or accessibility of services to beneficiaries, the Committee doubts that the States, many of which are under severe fiscal pressure, need to be required to achieve such savings. The Committee bill therefore revises the current home and community-based services waiver authority to nullify some of the Secretary's regulatory actions and further clarify Congressional intent.

The current statutory authority allows States to offer "habilitation services" to individuals under a waiver. Nonetheless, in the preamble to the March 13, 1985, regulations, the Secretary flatly prohibits States from offering prevocational and vocational training and educational activities under a waiver. 50 Fed. Reg. at 10020. The Committee can see no justification for such a narrow statutory construction. Experience conclusively demonstrates that access to appropriate day services, including educational and prevocational or vocational training, is essential to enabling many mentally retarded and other developmentally disabled clients to achieve and retain independence in community settings. The Committee bill accordingly clarifies that the term "habilitation services" means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside outside of an institution, including prevocational, educational, and supported employment services. These services may be offered under the waiver only to individuals who are discharged from an SNF, ICF, or ICF/MR.

In order to avoid duplication of Federal expenditures, the Committee bill specifies that States may not cover these prevocational, educational, and supported employment services under the waiver

if these services are "otherwise available" to the individual through a local educational agency or a program funded under section 110 of the Rehabilitation Act of 1973. The Committee expects that the relevant State Medicaid and Vocational Rehabilitation agencies and the local educational agencies will coordinate their efforts in this regard so as to maximize the number of individuals receiving these services under the "2176 waiver" and the other Federally-assisted programs. The Committee intends that the Secretary and the States, in interpreting the phrase "otherwise are available," deny coverage for these services to a client under a "2176" waiver only if that client has been determined eligible for the special educational or vocational rehabilitation services offered by other agencies and if the client is actually receiving, or will actually receive, these services under these other programs.

The Committee bill clarifies that, in determining whether a State has met the budget neutrality test for the granting of a waiver, the Secretary is to satisfy herself that the average annual per capita expenditures estimated by the State for individuals under the waiver does not exceed 100 percent of the average annual per capita expenditures that the State reasonably estimates would have been made in the absence of the waiver. The Subcommittee on Health and the Environment heard testimony from State officials that, in reviewing and approving State waiver applications, the Health Care Financing Administration was applying an unwritten rule that the estimated expenditures under the waiver could not exceed 75 percent of the estimated expenditures in the absence of the waiver. This rule is not articulated in either the March 13, 1985, regulations or any other administrative guidelines. It does not have, and never has had, any statutory basis, and the Committee expects that the Secretary will discontinue its use forthwhile.

The March 13, 1985, regulations require, at 42 C.F.R. 441.302(e)(2), that a State give assurance that its actual total expenditures for home and community-based services under the waiver, and its claim for Federal Medicaid matching payments for these services, will not exceed the State's approved estimates for these services, expressed as the product of the estimated number of individuals receiving services under the waiver and the estimated expenditure per person. Similarly, the new 42 C.F.R. 441.310(a)(2) provides that Federal financial participation is not available in expenditures for home and community-based services that exceed the State's approved estimated total expenditures for these services. There is no statutory basis for such a limitation, which has the chilling effect of placing the States totally at risk for the cost of their waiver programs. The only limit which the Secretary is authorized to impose on State expenditures under the waiver is the budget neutrality test stated in section 1915(c)(2)(D) of the Act. The Committee bill expressly prohibits the Secretary from imposing the types of conditions and limits on Federal financial participation reflected at 42 C.F.R. 441.302(e)(2) and 441.310(a)(2).

At its June 25, 1985, hearing on this subject, the Subcommittee on Health and the Environment heard testimony from a 37 year old cerebral palsy victim who lives in a nursing home not because she needs nursing care, but because she needs assistance in person-

al care. Pennsylvania's Medicaid program will pay for her care in an ICF, but cannot, under regular Medicaid law, pay for the services she needs to live in the community. The State sought a "2176" waiver from the Secretary to deinstitutionalize this witness, and about 140 other severely disabled but mentally alert adults from nursing homes in Allegheny County over three years. The Secretary rejected the State's estimated expenditures as "unacceptable" because, in calculating average per capita expenditures, the State used only the costs associated with the disabled residing in SNFs or ICFs in Allegheny County, not the statewide averages for all SNF or ICF patients, including the elderly. The Secretary erred.

The current waiver statute, section 1915(c)(2)(D), directs the Secretary to review the average per capita expenditures of "such individuals"—that is, the individuals at risk of nursing home care who are to receive services under the waiver. It is obvious that the physically disabled young adult population is completely different than the frail elderly, even though both, in this instance, happen to reside in SNFs or ICFs. Thus, to include elderly SNF or ICF patients in a cost calculation for a waiver targeted at physically disabled young adults is inappropriate and contrary to the statute. Similarly, to use statewide averages for SNF and ICF expenditures when the waiver, by its own terms, is limited to a particular country, is inappropriate and contrary to the statute. The Committee wishes to emphasize that, in determining whether the budget neutrality test of section 1915(c)(2)(D) has been met, the Secretary is to use cost information reflecting the populations and geographic areas most closely comparable to the populations and areas targeted to receive home and community-based services under the waiver. To further clarify this principle, the Committee bill explicitly provides that, in the case of physically disabled individuals who are residents of SNFs or ICFs, the State may determine the expenditures that would have been made for these individuals on the basis of the costs of that particular population in the SNFs and ICFs in that area.

The Committee bill allows States, at their option, to set the income that an individual receiving services under a waiver may retain for his or her maintenance needs at a level higher than that allowed under current regulations, 42 C.F.R. 435.725, 42 C.F.R. 435.735. These regulations, published on March 13, 1985, limit the amount that an individual is allowed for maintenance needs to the higher of (1) the SSI income standard, (2) the optional State supplement standard, or (3) the medically needy income standard. A parallel rule applies in States which apply more restrictive requirements for Medicaid eligibility than SSI. The Subcommittee on Health and the Environment heard testimony from State officials that these limits on maintenance needs levels are far too restrictive. The Committee is concerned that the lack of adequate income to maintain oneself at home may prevent the participation of appropriate clients in the "2176" waivers. Given the budget neutrality requirements of the waiver, the Committee can see no justification for the imposition of arbitrary post-eligibility income limits. The more a State allows an individual to keep for maintenance needs, the less patient income there is available to reduce Medicaid expenditures, and the higher the Medicaid average per capita cost.

If costs rise to the point where the State can no longer demonstrate budget neutrality, then the waiver will be denied. In short, the State faces a direct trade-off between Medicaid expenditures and income contributed by the patient. Constrained by budget neutrality, a State could reasonably determine that, in order to facilitate community placement of individuals at risk of nursing home care, it wants to require that individual to apply less of his or her income to the costs of care than required by the current regulations. Accordingly, the Committee bill would allow a State to set an individual's maintenance needs income level at amounts higher than the maximums imposed under 42 C.F.R. 435.726 and 435.735. Of course, whatever higher levels a State selected would have to apply uniformly to all individuals covered by the waiver.

The Committee bill clarifies that individuals who, but for the receipt of home and community-based services, would continue to receive inpatient hospital services under Medicaid because they are dependent on ventilator support, are also eligible for coverage under a "2176" waiver. Testimony before the Subcommittee on Health and the Environment indicates that recent advances in medical technology and practice have greatly expanded the potential for successful home treatment of ventilator-dependent individuals, especially children. The Committee expects that the Secretary will, to the maximum extent possible, assist the States in using the "2176" waivers to finance home and community-based services for these individuals where home care is medically and socially feasible and appropriate.

The Committee recognizes that the Medicaid program cannot function as the sole financing mechanism for the deinstitutionalization of ventilator-dependent children. Private sector resources are needed as well. The Committee bill therefore directs the Secretary to establish a task force to identify barriers to the provision of home or community-based care to technology-dependent children, and to recommend changes in private and public health care programs that will eliminate such barriers. The task force, which is to be composed of representatives from Federal and State child health agencies, private health insurers, large employers, providers, and parents, is to report to the Congress within two years of enactment.

The Committee notes that its bill does not address all of the imperfections in this regulation. In particular, the Committee bill does not modify the new 42 C.F.R. 441.302(f), which requires a State to provide documentation for, among other things, the estimated average per capita expenditures in the absence of the waiver. The regulation requires States to provide the number of actual and projected beds, by type, in Medicaid certified skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICFs/MR); evidence of the need for additional bed capacity in the absence of the waiver; the estimated annual number of beneficiaries who will be deinstitutionalized from certified SNFs, ICFs, and ICFs/MR because they would receive home and community-based services under the waiver; and the estimated annual number of beneficiaries whose admission to such institutions would be diverted or deflected because of the waiver.

The preamble to the regulations explains that the Department needs this information "to determine whether a State would have the capacity to provide institutional care in the absence of a waiver to those individuals who will receive home and community-based services. If the State would not have adequate bed capacity to institutionalize these individuals, its estimates may be found unreasonable." (This is a reference to the statutory language that the State must "reasonably" estimate its expenditures in the absence of the waiver). Similarly, if a State is "merely" proposing to divert individuals from institutional placement, the State must "provide additional evaluation methods to assure that services will be restricted to persons who would otherwise receive institutional care," 50 Fed. Reg. at 10018.

The effect of these requirements, imposed under the guise of "cost-effectiveness," is to reward States where the number of nursing home beds is growing, and to penalize the States that have restricted nursing home bed growth. States that, for reasons of fiscal restraint, have chosen to limit or freeze nursing home bed growth will not be able to demonstrate that the individuals to whom they wish to offer home and community-based services would, in the absence of a waiver, be institutionalized. Lengthy waiting lists for nursing home placement would probably force those individuals to remain at home—without needed services—or in a hospital. Because these individuals would never be admitted to a nursing home, the Department contends, they do not represent a cost that would be incurred by Medicaid in the absence of the waiver. By the same faulty reasoning, otherwise eligible individuals whom the State proposes to divert from institutional placement will represent a new cost to the Medicaid program because they would never have been admitted to a home without the waiver.

As the aging of our population leads inexorably to increased demand for long-term care, Sates will have essentially three policy choices: to create a delivery system that offers both nursing home services and home and community-based alternatives; to rely largely on expansion of nursing home bed capacity to meet the growth in demand; or to constrain both community-based and institutional capacity, allowing the very sick long-term care patients to back up in hospitals waiting for nursing home placements. The "2176" waiver, as enacted by Congress, is neutral on these choices; it merely gives States that choose the first option the ability to redirect some Medicaid dollars away from institutional care. As rewritten by the Secretary through the March 13, 1985, regulations, the "2176" waiver authority is no longer available to States that wish to pursue the community care option. The Committee believes that, in the long run, the Secretary's misguided "cost-effectiveness" policy will prove quite costly to Federal and State government alike by forcing the expansion of expensive institutional capacity.

The Committee wishes to make clear that this perverse result is neither authorized nor intended by the current waiver statute. When the statute provides that expenditures in the absence of the waiver must be "reasonably" estimated, it does not suggest that States would be unreasonable in choosing not to expand their institutional capacity. The Congress never intended to discourage the States from limiting the growth of nursing home beds; instead, the

Congress sought to give the States an option for developing home and community-based alternatives to nursing home care for those at risk within the constraints of budget neutrality. It is the expectation of the Committee that the Secretary will reconsider her policy in this regard and bring the March 13 regulations into conformity with Congressional intent. The Committee bill does not, however, expressly overrule 42 C.F.R. 441.303(f) because the Congressional Budget Office (CBO) has indicated such action might result in a budget effect. While the Committee respectfully disagrees with the CBO analysis, the Committee is, under the conventions of the budget process, obliged to accept it. However, the Committee wishes to emphasize that its inaction in this regard is not be construed as agreement with, or acquiescence in, the irrational "cost-effectiveness" policies reflected in 42 C.F.R. 441.302(f).

Optional hospice benefits (sec. 203)

Hospice care is an alternative approach to treatment of terminally ill patients. Its purpose is not to cure the patient but to provide medical relief from pain and to enable the patient to remain in the home as long as possible. Palliative and counseling services are provided to both the patients and their families. Under current law, many of the services that hospices provide—home health care, prescription drugs, physician services, physical therapy, and short-term inpatient care—are covered under State Medicaid programs as individual services. There is no statutorily-recognized category of hospice care or hospice provider. The only potential for covering hospice care as a separate service is under the current home and community-based services waiver authority.

Since the mid-1970's, with the emergence of the hospice movement in this country, terminally ill individuals with means have had the opportunity to receive hospice care. Since 1983, terminally ill Medicare beneficiaries have had the option of electing hospice services in lieu of most other Medicare benefits. In the view of the Committee, the terminally ill poor who are eligible for Medicaid should have the same basic choice.

The Committee bill allows States, at their option, to offer hospice care, delivered by public or private nonprofit hospice programs, to terminally ill individuals who have voluntarily elected to receive hospice care in lieu of certain other benefits. Terminally ill individuals are those with a medical prognosis of a life expectancy of 6 months or less. For Medicaid purposes, the terms "hospice care" and "hospice program" would have the same content as under Medicare. The Committee bill allows the States to limit the amount, duration, or scope of the hospice care they choose to cover, but the limitations may not be more restrictive than those under Medicare. States choosing to offer hospice coverage would be required to use Medicare payment rates and methods. Individuals residing in nursing homes who are currently eligible for Medicaid on the basis of a special income standard could, at State option, elect to receive hospice services at home and remain eligible under the same income standard. As in the case of hospital or nursing home patients who retain only a small personal needs allowance, hospice patients may not be subjected to copayments or other cost-sharing requirements.

To assure that an individual's choice of hospice benefits is voluntary, the Committee bill requires that the State's procedures be consistent with those in effect under Medicare, and provides that the individual may revoke his or her choice of a hospice at any time, without a showing of cause. Thus, while a State may require an individual electing hospice benefits to waive rights to payment with respect to most services related to the treatment of the individual's terminal illness, including those which are duplicative of the services the hospice is being paid to provide, the State may not require an individual to waive payment for services delivered by his or her attending physician, except where the physician is an employee of the hospice program. States may limit the period of time for which they will pay for hospice services, but in no case may these limitations be more restrictive than those under Medicare, which allows coverage for 2 ninety-day periods and 1 thirty-day period.

Under the Committee bill, States choosing to cover hospice services would be required to follow the Medicare definitions of "hospice care" and "hospice provider," except that for-profit entities would not be eligible for Medicaid hospice payment. Thus, pursuant to a written plan of care established and periodically reviewed by the individual's attending physician, a "hospice program" would be required to offer the nursing care, home health aide services, medical supplies, drugs, physicians services, counseling, medical social services, physical or occupational therapy, or short-term inpatient care as needed by the patient on a 24-hour basis, as well as bereavement counseling for the immediate family. All of the so-called "core services"—nursing care, medical social services, physicians' services, and counseling—must routinely be provided directly through the hospice program, and not through arrangements with other providers, except where waived by the Secretary.

Under Medicare, hospice programs are to be paid for the costs that are reasonable and related to the costs of providing hospice care, but not for the costs of bereavement counseling, subject to a "cap amount." The Secretary, by regulation, has implemented a prospective payment methodology for hospice care under which hospices are paid one of four predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the level of care received by the beneficiary that day: routine home care, continuous home care, inpatient respite care, general inpatient care. Under the Committee bill, States choosing to offer the hospice benefit would be required to reimburse participating hospices according to this methodology, paying the same amount for a Medicaid patient as the hospice receives for a Medicare patient for the same category of service day. The Committee is concerned that, in the absence of such payment uniformity, financial incentives may lead to discrimination against, and inferior treatment of, Medicaid patients.

The Medicare program also limits the total amount that Medicare will pay to a particular hospice in a year to the product of the "cap amount" for that year multiplied by the number of Medicare beneficiaries in the hospice that year. The Medicare "cap amount" is currently $6,500, adjusted annually by the medical component of the consumer price index. Under the Committee bill, States are not

required to apply this aggregate limit on Medicaid hospice care expenditures. They may apply such a limit if they so choose; however, as with other amount, duration, and scope restrictions on the hospice care benefit, it may not be more restrictive than the prevailing Medicare limit.

Unlike the Medicare program, with its uniform eligibility rules, many State Medicaid programs have established different eligibility standards for individuals who are institutionalized. More than half of the States apply a higher income standard—up to 300 percent of the Supplemental Security Income benefit rate—to individuals in nursing homes and other medical institutions. To avoid the loss of the special income standard—and therefore eligibility for benefits—by a terminally ill patient who wants to return home under the care of a hospice, the Committee bill allows States, at their option, to apply this special income level in determining eligibility for hospice care. The rules regarding post-eligibility treatment of income and resources applicable to hospice patients would be identical to those applying to individuals receiving home and community-based services under a section "2176" waiver.

This provision is effective for Medicaid payments for hospice care made on or after October 1, 1985.

Payments for direct medical education costs of hospitals (sec. 204)

Under current law, States are required to pay for hospital services under Medicaid according to rates that are reasonable and adequate to meet the costs that would be incurred by an efficiently and economically operated facility providing care in compliance with all applicable requirements. This gives the States considerable discretion in developing payment methodologies and there is a wide variety of payment systems now in use among the State programs.

The costs incurred by some hospitals include those generated by their graduate medical education programs. The term "direct medical education costs" is used here to describe the costs of stipends and fringe benefits for residents and interns, as well as the costs of faculty and supervisory personnel, space and equipment, and other administrative and overhead expenses. The State payment methodologies currently account for and reimburse these costs in diverse ways.

The Committee bill would revamp the methodologies for paying for direct medical education costs and require all States to pay for such costs in a consistent manner. The purposes of this provision include eliminating unnecessary expenditures, encouraging efficiency, simplifying the current complicated payment methodologies, and removing impediments for primary care programs.

All payments would be made on the basis of each hospital's historical costs per resident. Once calculated, that amount would not be allowed to rise faster than the general rate of inflation. In addition, it would be subject to a ceiling, expressed as a percentage of the median of such amounts for all hospitals. The amount which a hospital would get paid under Medicaid for direct medical education would be the product of three components: the hospital-specific "approved amount" per resident, just described; multiplied by the number of full-time equivalent residents; multiplied by the propor-

tion of the hospital's total inpatient days used by Medicaid patients.

The Secretary of Health and Human Services would be responsible for calculating, for each hospital, the average allowable cost for a full-time resident. The Secretary would use the most recent, audited Medicare cost report available for each hospital and would use the Medicare terminology and methods for determining the total allowable costs for direct medical education. The average amount per full-time resident would be obtained be dividing the total allowable costs by the number of full-time equivalent residents and interns in approved graduate medical education programs, as defined for purposes of Medicare. (The Committee bill does not address payment methodologies for nursing education or other allied health professions training).

The amount calculated by the Secretary for the most recent available cost-reporting year would be updated for use during the period July 1, 1985, through June 30, 1986, using the percentage increase in the Consumer Price Index from the midpoint of the prior cost-reporting year to the end of December 1985. (Throughout this provision, the Committee bill uses a standard 12-month period beginning July 1 and ending June 30, for purposes of calculating the hospital specific approved amount per resident and the number of full-time residents. This accords with the standard period used for residency training programs and will facilitate implementation and monitoring of the provision. The bill does not, however, require hospitals to change their cost-reporting years or require States to change their Medicaid fiscal years or payment cycles.) The approved amount would continue to be updated annually by the percentage change in the CPI. Beginning on July 1, 1986, however, these hospital-specific amounts would also be subject to an upper limit and any amount by which a specific hospital's updated approved amount exceeded the upper limit would be disallowed.

This upper limit will encourage hospitals to examine their methods of administering these programs. Programs costs for the stipends of residents do not vary substantially among programs and institutions. However, the cost accounting rules now in effect result in considerable variations in administrative, overhead, and other programs costs. Absence a restraint like the limitations in the Committee bill, some of these costs may be excessive.

The upper limit would be calculated as a percentage of the median of all of the hospital-specific approved amounts. The limit on July 1, 1986, would be 175 percent of the median. On July 1, 1987, it would be 150 percent of the median and on July 1, 1988, it would be 125 percent of the median.

The calculations described in the preceding paragraphs would produce an approved amount per full-time resident for the 12-month period beginning on July 1 of each year. For hospitals on a July 1 through June 30 cost-reporting year, no further adjustment would be necessary and their Medicaid payments could be computed by multiplying this approved amount by the number of full-time equivalent residents and the hospital's Medicaid share of inpatient days. A simple formula would be used to adjust these calculations for hospitals with cost-reporting periods that do not begin on July 1 and, therefore, straddle two residency year periods. For these hos-

pitals, the approved amount for the first residency year falling within the cost-reporting period would be multiplied by the proportion of that residency year which falls within the cost-reporting year. This figure would then be multiplied by the number of full-time equivalent residents in the first residency year. The same calculation would be made with respect to the second residency year falling within the cost-reporting period—i.e., the approved amount for the second residency year would be multiplied by the proportion of the second residency year that falls in the cost-reporting year and this would be multiplied by the number of full-time equivalent residents in the second year. The results for each residency year would then be added together and multiplied by the hospital's Medicaid share of inpatient days during the cost-reporting year to arrive at the hospital's total Medicaid payment for direct medical education.

The Committee bill also includes two additional features designed to enhance residency programs in primary care and to overcome the economic incentives in the current payment methodologies that work to the disadvantage of primary care residencies. The first feature would expand the typical rules currently in effect regarding the time residents spend in ambulatory settings. The Medicare policy on this point, which is followed by many States, counts the resident's time in an ambulatory setting only if the setting is part of the hospital where the resident's program is located. If the resident is assigned to a different ambulatory setting, such as an HMO or free-standing clinic, his time there is not counted towards full-time equivalency in calculating the hospital's graduate medical education costs. Since these other ambulatory settings have difficulty in finding other sources to cover these costs, such assignments are discouraged. This has a particularly strong detrimental effect on primary care programs, which are the most likely to utilize such ambulatory settings. It also discourages programs from incorporating these enriching experiences into their scope of activity.

The bill would treat this issue by making it clear that all of the time a resident spends in activities related to patient care is to be counted for this purpose, irrespective of the setting or the organizational structure of the unit to which he is assigned.

The other feature which enhances primary care residencies entails weighting these residencies more heavily than others when calculating full-time equivalent residents. Beginning in July 1987, the number of residents in programs designated as primary care would multiplied by a factor of 1.10 in computing full-time equilvalent residencies. This factor would increase to 1.20 in July 1988 and to 1.30 in July 1989.

Primary care programs would be defined as the first three years of postgraduate training in internal medicine, pediatrics, and family medicine. They would also include up to two years in programs for geriatric medicine and programs in public health and preventive medicine, whether these two years occurred during the first three years of the resident's training or came later. However, it would not include residents who were participating in one of the programs otherwise designated as primary care, if they were doing so only as a prerequisite or prelude to training in another field and had already been selected for the other field.

The Committee recognizes that there is currently not a residency review committee for geriatric medicine and these programs are not approved by the Accrediting Council on Graduate Medical Education. However, there are quality programs in this field and they are expected to be approved by the ACGME in the near future. Meanwhile, it is the Committee's intention that the Secretary review these programs and approve, for purposes of this provision, those which meet satisfactory standards.

Residents in training programs other than those designated as primary care would be further divided into two groups for purposes of this provision. One group would include residents in non-primary care programs during the minimum number of years of training, not to exceed five years, necessary to satisfy the requirements for initial board certification in that field. Beginning in July 1987, the number of residents in this group would be multiplied by a factor of .90 in computing full-time equivalents. The factor would change to .80 in July 1988 and to .70 in July 1989.

The final group would include all other residents. Beginning in July 1987, the number of these residents would be multiplied by a factor of .75 in computing full-time residents. Beginning in July 1988 and thereafter, they would be multiplied by a factor of .50.

These factors are used only to calculate the amount of Medicaid reimbursement to hospitals for graduate medical education. They are not intended to regulate how hospitals or training programs distribute the money. In particular, they are not intended to create differentials in the stipends or other compensation that hospitals pay to various groups of residents. These factors are devised solely to recognize that some programs have less ability to generate revenues than others. It is the Committee's expectation that hospitals and training programs will be able to augment these Medicaid resources with other resources, particularly in the case of residents in training programs after the period needed for initial board certification.

The continuation of many primary care programs is threatened by the current financial situation. Most of the money for graduate medical education comes from payments for the patient care delivered in the course of those training programs. Specialties that perform surgical or other highly technical procedures and that hospitalize a substantial percentage of their patients can generate far more revenue than ones that rely principally on outpatient care and simple courses of treatment. In particular, programs in family medicine, internal medicine, and pediatrics, as well as those in geriatric medicine and public health and preventive medicine, are at a serious financial disadvantage.

Given the current reimbursement system for hospitals and physicians, and faced with proposed reductions in those reimbursements, primary care programs that cannot generate inpatient revenues are now in danger of disappearing.

Witnesses at the hearing held by the Subcommittee on Health and the Environment were unanimous that primary care programs would be the first to be cut if current trends continue. Many stated that this is already taking place. These cuts are based on financial reasons, not on a reluctance by students to enter those or on questions about the quality of the programs.

It has proved very difficult to predict how many physicians in what specialties will be needed in the future. Most major studies use complex methodologies and their results have been questioned. Nevertheless, the studies that do exist all show that the greatest excess numbers are found in the subspecialties and surgical specialties. All the areas with surpluses projected for 1990 by the Graduate Medical Education National Advisory Committee [GMENAC] were subspecialties, surgical specialties, and other highly technical fields. Reductions in the number of primary care training positions would not only threaten to produce shortages of primary care physicians, they would also exacerbate the surpluses in other fields.

More important, if primary care training programs are cut heavily, young physicians will be denied the option to choose these fields.

Major reforms, beyond those proposed in this bill, will be needed in both hospital and physician reimbursement before primary care is put on an even footing with other specialties. The Committee bill, however, represents an important contribution to that goal. By 1989, when the weighting factors are fully phased in, primary care programs would be receiving a significant differential payment to help remove them from their current precarious position and put them on more secure footing.

There may be better ways of achieving this objective, and the weighting factors may turn out not to be as effective as intended. Moreover, other conditions may change in ways that raise questions about the continued use of these weighting factors. Therefore, the Committee bill calls for the Physician Payment Review Commission, which is established by 102 section in the bill, to evaluate this provision and to make recommendations for changes in the weighting factors or alternative methods of calculating full-time equivalents. The Secretary would be authorized to implement such recommendations, without obtaining further legislative authority, beginning on or after July 1, 1989.

The bill would reinforce the current rules pertaining to foreign medical graduates. Under current Medicare policy, followed by most States, payments are not to be made unless the resident is an approved residency program. Moreover, under the policies of ACGME, a resident is not to be permitted in an approved program unless he or she has met various requirements, including passing the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) or its predecessors, the ECFMG or VQA. However, the Committee has been advised that these rules and policies are not consistently monitored and enforced.

The bill would specifically require that a resident pass the FMGEMS test in order to be counted among the full-time equivalents used to compute Medicaid payments, beginning with the residency year that starts July 1986. A transition period would be provided for people currently serving as residents who have not passed the FMGEMS. During the residency year beginning July 1986, they would be counted at one-half the rate they would otherwise be counted, and would not be counted at all for subsequent residency years if they had still failed to pass the test. Since the test is offered twice a year, this gives residents several opportunities to pass it. There would also be an exception for residents who had previ-

ously been certified by the Educational Commission for Foreign Medical Graduates and are not permitted by the ECFMG to take the FMGEMS.

Treatment of potential income from medicaid qualifying trusts (sec. 205)

Current Medicaid law contains a number of provisions designed to assure that individuals receiving nursing home and other long-term care services under Medicaid are in fact poor and have not transferred assets that should be used to purchase the needed services before Medicaid benefits are made available. States may presume that individuals who dispose of assets, including a home, for less than fair market value within two years of applying for Medicaid have done so in order to qualify for the program. Unless the individuals are able to demonstrate otherwise, the States may deny them Medicaid coverage for a period that bears a reasonable relationship to the uncompensated value of the assets. In addition, States may impose liens on the homes of Medicaid nursing home patients prior to death under certain circumstances.

It has come to the attention of the Committee that some attorneys and financial advisors have suggested to their affluent clients that, as a matter of estate planning, they consider placing most of their assets into a specially designed irrevocable trust. Under current Supplemental Security Income (SSI) program policy, which is followed by most State Medicaid programs, the principal or income from irrevocable trusts are not considered resources to the beneficiary or applicant, because the asset is no longer "available" to the grantor. (However, any payments actually distributed to the grantor under the terms of the trust are treated as income to the recipient). Establishment of such an irrevocable trust will therefore allow the grantor to receive income until institionalization becomes necessary, and then to qualify for Medicaid nursing home coverage and preserve the remaining assets for their non-disabled children after death. Some such trusts may even permit the individual to continue to receive income while institutionalized, up to the applicable Medicaid eligibility limits.

For example, the "Personal Business" column in the March 11, 1985, issue of Business Week advised readers that, ". . . at $20,000 to $50,000 a year, a prolonged stay in a nursing home can be financially devastating. With some advance planning, however, you may be able to ease the burden. . . . As distasteful as the mere idea of pleading poverty may be, you might find consolation in knowing that such a plea can ultimately allow you to obtain a highly valuable Medicaid card. To get one, you must technically fall within the medically needy category. But can you get there legally? 'The same people who rely on tax planning and make use of every loophole in the tax laws to build up their assets,' says [Charles Robert of Robert & Schneider, a law firm in Hempstead, N.Y., specializing in the health care problems of the elderly], 'can use the same techniques to keep them—and still qualify for Medicaid.'" The article goes on to explain how these "techniques" work: "Basically, the idea is to place any assets you hope to protect—funds for your grandchildren's education or stocks you plan to leave to your own youngsters—in an irrevocable living trust for them. Such trusts

have their own advantages: They can reduce your income taxes by routing income to the minors while the assets themselves stay intact. Also, you can give the trustee specific instructions on how the trust assets are to be handled during your lifetime. And the trust that you create becomes a separate taxpaying entity, so you or your spouse no longer need list its assets if you ever do have to file a Medicaid application.

Attorneys in need of technical assistance in this regard can draw upon such publications as that of Massachusetts Continuing Legal Education, Inc., entitled "Estate Planning for Medicaid Coverage of Nursing Home and Long Term Health Care" (84–3), which contains a sample "Medicaid Qualifying Grantor Trust."

The Committee feels compelled to state the obvious. Medicaid is, and always has been, a program to provide basic health coverage to people who do not have sufficient income or resources to provide for themselves. When affluent individuals use Medicaid qualifying trusts and similar "techniques" to qualify for the program, they are diverting scarce Federal and State resources from low-income elderly and disabled individuals, and poor women and children. This is unacceptable to the Committee.

The Committee bill provides that for purposes of determining Medicaid eligibility, the amounts deemed available to a grantor of a Medicaid qualifying trust is the maximum amount of payments permitted to be distributed under the terms of the trust to the grantor, assuming the full exercise of discretion by the trustee or trustees for the maximum distribution to the grantor. For these purposes the grantor includes not only an individual who establishes a Medicaid qualifying trust, but also an individual whose spouse establishes such a trust whether or not at the individual's direction.

The Committee bill defines a Medicaid qualifying trust as a trust, or similar legal device, irrevocable or not, established by an individual (or an individual's spouse) under which the individual may be a beneficiary of all or part of the payments from the trust, and under which one or more trustees are given any discretion whatsoever with regard to the amounts to be distributed or the purposes for distribution. For this purpose, the term "discretion" includes actions taken by a trustee in accordance with instructions to supplement cash or medical assistance benefits by specific amounts.

Under the Committee bill, the actual distributions made to a grantor from such a trust are not relevant for Medicaid eligibility purposes; what is determinative is the maximum amount that a trustee could, in the full exercise of discretion for the distribution of the maximum amount to the grantor, distribute to that grantor, whether from income or from principal. Whether the trust was established for the purpose of enabling the grantor or some other individual to qualify for Medicaid is irrelevant.

This provision applies only to trusts in which the grantor (including an individual whose spouse has established such a trust) may benefit from the trust. The Committee does not intend that trusts established solely for the benefit of disabled children, from which the grantor or other individual can under the terms of the trust receive no benefit, be treated as Medicaid qualifying trusts.

The Committee bill would apply in those States that automatically extend Medicaid benefits to SSI recipients and those that do not. It would apply to all applicants and beneficiaries, whether categorically needy, optional categorically needy, or medically needy. The provisions does not, however, authorize States to apply standards more restrictive than those set forth in the Committee bill to beneficiaries of Medicaid qualifying trusts, such as deeming available to a beneficiary assets that have been irrevocably placed in trust and over which the trustee can exercise no discretion whatsoever. Similarly, the Committee bill does not authorize States to treat as resources for Medicaid eligibility purposes the assets in other types of irrevocable trusts, such as those established solely for the benefit of disabled children.

The provision is effective for Medicaid payments made on or after the first day of the second month after enactment. Thus, Medicaid qualifying trusts that have already been established, as well as those that may be created in the future, would be subject to the provision. The Committee is aware that the applicability of this provision to trusts already established may cause some disruption in the financial affairs of the grantors. However, the Committee is persuaded that this disadvantage is greatly outweighed by the restoration of fiscal integrity to the Medicaid program that this provision will accomplish.

Written standards for provision of organ transplants (sec. 206)

Under current law, States are required to cover certain services, such as inpatient hospital and physician services, in an amount, duration, and scope sufficient to reasonably achieve their purpose. States may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition. Although organ transplant procedures necessarily involve inpatient hospital, physician, and other required services, State limitations on the provision of these required services in the case of individuals requiring organ transplants are not viewed as arbitrary due to the unique nature and extraordinary costs of such procedures. Thus, States may elect to cover non-experimental, non-cosmetic organ transplant procedures under their Medicaid programs and receive Federal matching funds.

According to a survey conducted by the Intergovernmental Health Policy Project and the Health Care Financing Administration in April, 1985, a total of 18 States reported having no formal guidelines or policies governing reimbursement for organ transplants. (The States are Alabama, Alaska, Arizona, Colorado, Delaware, Florida, Kentucky, Maine, Mississippi, Montana, Nevada, New Hampshire, North Dakota, South Carolina, Virginia, Washington, West Virginia, and Wisconsin). Most States with no formal guidelines have reimbursed for transplants on an ad hoc basis, or according to informal criteria developed within the State Medicaid agency.

While the Committee believes that the decision to extend Medicaid coverage for one or more organ transplant procedures is appropriately within the province of each State, the Committee does not believe that this decision can equitably be made on an ad hoc, case-

by-case basis. There is, in the Committee's view, no justification for a State to deny payment for a particular transplant procedure to one Medicaid beneficiary and to approve payment for that same procedure for another, similarly situated beneficiary. Access to organ transplant coverage should not dependent upon a family's ability to draw sympathetic media coverage or favorable dispensation from elected officials.

The Committee bill therefore requires that, in order to receive Federal Medicaid matching payments for organ transplant procedures after July 1, 1986, a State must have written standards, set forth in its Medicaid plan, regarding the coverage of such procedures. These standards must provide that similarly situated individuals are treated alike—that is, that the State's criteria are applied fairly and uniformly to all individuals eligible for Medicaid in the State. The standards, which may include medical patient selection criteria, must be reasonable.

The Committee wishes to emphasize that its bill does not require a State to cover any organ transplant procedures. Under the bill, States also have the discretion to cover some procedures, such as liver and bone marrow transplants, but not others, such as heart or heart-lung transplants. However, if a State decides to cover any procedures, it must establish formal written standards and apply them fairly and uniformly.

Under the Committee bill, a State may limit the facilities or practitioners to whom it will make payment for the organ transplant procedures it chooses to cover. In view of the extraordinary expense and complexity of these procedures, a State could justifiably decide to commit its resources only to those facilities and practitioners of demonstrated excellence with regard to a particular procedure, whether located in that State or not. If a State chooses to restrict the facilities or practitioners in this manner, it must assure that the designated providers render high quality care and that they are accessible, through transportation arrangements made or paid for by the State, to all Medicaid beneficiaries throughout the State.

Deemed residence for out-of State adoptive and foster care placements (sec. 207)

Under current law, children with respect to whom adoption assistance or foster care payments are made under Title IV–E of the Social Security Act are eligible for Medicaid as categorically needy beneficiaries. The State which makes the Title IV–E payment is also the State which provides the Medicaid coverage.

In the case of out-of-State adoption assistance or foster care placements, providers may be unwilling to accept an out-of-State Medicaid card, unnecessarily jeopardizing the child's access to needed medical services. This can be a particularly serious problem for children receiving adoption assistance payments, many of whom have handicapping conditions. Recognizing this problem, the American Public Welfare Association, which represents State Medicaid directors, has developed an Interstate Compact on Adoption and Medical Assistance which provides that children receiving adoption assistance payments are eligible to receive Medicaid benefits from the State in which they live. In the view of the Commit-

tee, this arrangement furthers the purposes of both the Medicaid and Title IV–E programs.

The Committee bill therefore provides that, for purposes of Medicaid eligibility, children with respect to whom Title IV–E payments are made are residing in the State in which they actually live, not the State which issues the Title IV–E payment. The provision is effective in the first calendar quarter beginning more than 90 days after enactment.

It has recently come to the Committee's attention that the Department, through an Action Transmittal Notice dated June 4, 1985, has erroneously instructed the States that the income and resource standards used for determining Medicaid eligibility for adoptive and foster care children receiving State payments cannot be the same as those used for children receiving Federal Title IV–E payments. The Committee wishes to clarify that, in determining Medicaid eligibility for children receiving State-subsidized adoption and foster care payments (if such children are covered under a State's Medicaid plan), a State should extend Medicaid coverage to children with State payments even in cases where those payments exceed AFDC payments under Title IV–A. Furthermore, as under Title IV–E, States should not consider the income and resources of adoptive or foster families in determining an adoptive or foster child's eligibility for Medicaid when that child is receiving State and not Title IV–E payments. To the extent the Action Transmittal Notice directs States to use more restrictive income or resource standards for non-Title IV–E adoptive or foster care children, such instructions are erroneous and should be disregarded.

Extension of MMIS deadline (sec. 208)

Under current law, States were required to have in operation, by September 30, 1982, a Medicaid Management Information System (MMIS) that has been approved by the Secretary as meeting Federal performance standards. Failure to meet the deadline subjects a State to a reduction of Federal matching payments for administrative costs. The Secretary is authorized to waive this penalty if she determines that a State is unable to comply for good cause or due to circumstances beyond its control. The Secretary has defined contractor failure as a circumstance beyond a State's control, 50 Fed. Reg. 4801 (Feb. 1, 1985).

Maryland did not achieve certification of its MMIS until April 1, 1985. It is the Committee's understanding that the State's failure to meet the statutory deadline resulted from the failure of a succession of contractors on whom the State had relied to develop an MMIS. The Secretary has denied Maryland's request to waive the penalty, even though the Secretary did waive the penalty in the case of another State where, the Committee is informed, certification was delayed due to contractor failure. Maryland is the only State to have been subjected to a penalty. All States now have a certified MMIS in operation.

Under these circumstances, the Committee can see no compelling reason to allow the Secretary to impose a penalty upon Maryland. The Committee bill therefore extends the deadline for the operation of a certified MMIS from September 30, 1982, to September 30, 1985.

Extension of certain waiver project (sec. 209)

Until March 1, 1980, the State of Texas offered intermediate care facility (ICF) services to a certain population of elderly in need of "level II" care. At that time, the State closed intake to all new ICF–II applicants and has not paid for the placement of any new Medicaid patients in ICF–II beds. However, the State has continued to pay for the institutional care of those who resided in ICF–II beds prior to that date. In addition, the State has paid for services at home to certain Medicaid-eligible individuals who need ICF level II care, including those who were institutionalized prior to March 1, 1980, and those who applied for benefits since that time but were never institutionalized. In order to offer Medicaid coverage to these groups, the State requested, and received, waivers of various Medicaid requirements under section 1115 of the Social Security Act ("Alternatives to the Institutionalized Aged," Project No. 11–P–97473/6–06).

The waiver expires on December 31, 1985. In the absence of the waiver, the State will have to make alternative provisions for the approximately 3,500 elderly nursing home residents and the roughly 2,000 elderly who are receiving Medicaid-covered services at home. These alternatives could well entail additional costs to the Federal government if, for example, the population now receiving services at home were institutionalized. The Committee bill therefore directs the Secretary to extend the current 1115 waiver until December 31, 1988, subject to the same terms and conditions as currently apply.

Report on adjustments for "disproportionate share" hospitals (sec. 210)

Under current law, States, in establishing payment rates for inpatient hospital services, are required to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. These "disproportionate share" hospitals tend to have extra overhead costs and higher staffing ratios which reflect the special needs of their patient populations for the services delivered by medical social workers, translators, and nutritional and health education personnel. In addition, these facilities often have high standby costs for trauma units, burn units, neonatal intensive care units, psychiatric emergency services, and other regional services. As providers of last resort, many of these facilities must care for significant numbers of high-cost, uninsured patients who are "dumped" by other hospitals for economic reasons.

The Committee bill directs the Secretary to submit a report to Congress no later than July 1, 1986, which (1) explains the methodology used by each State to take into account the higher costs of "disproportionate share" hospitals; (2) identifies each of the facilities that have had their payments adjusted; and (3) describes, for each of the "disproportionate share" hospitals, the proportion of total inpatient days attributable to low income patients (those with incomes below the official U.S. poverty threshold who are not covered by Medicaid), and the proportion of total inpatient days attributable to Medicaid patients. The Committee is aware that the Sec-

retary has, to date, failed to respond to a similar directive, set forth in section 2315(h) of P.L. 98-369, with regard to the Medicare adjustment for "disproportionate share" hospitals. The Committee expects that the Secretary will timely and fully comply with its directive.

Reference to other provisions of law (sec. 211)

There are a number of provisions of law that do not appear in Title XIX of the Social Security Act which either confer Medicaid eligibility on specified individuals or directly affect the Medicaid program. The Committee bill would simply incorporate into Title XIX references to such provisions of law for purposes of statutory coherence. The Committee does not intend any substantive change whatsoever in any of the referenced provisions.

Hearings

The Committee's Subcommittee on Health and the Environment has held 7 hearings on issues addressed in H.R. 3101.

On July 17, 1985, The Subcommittee held a hearing on deficit reduction proposals affecting Medicare Part B. Testimony was received from 16 witnesses, representing 15 agencies and organizations.

On June 25, 1985, the Subcommittee held a hearing on the administration of the Medicaid home and community-based services waiver by the Health Care Financing Administration and the Office of Management and Budget. Testimony was received from 9 individuals, 4 of whom represented State or Federal agencies.

On April 26, 1985, the Subcommittee held a hearing on physician payment under Medicare. Testimony was received from 11 witnesses, representing 10 agencies and organizations.

On April 3, 1985, the Subcommittee held a hearing on Medicare and Medicaid support for medical education. Testimony was received from 15 witnesses, representing 15 agencies and organizations.

On February 25, 1985, the Subcommittee held a hearing on preventing low birthweight births. Testimony was received from 5 individuals, 4 of whom represented the Committee to Study the Prevention of Low Birthweight of the Institute of Medicine of the National Academy of Sciences.

On January 27, 1984, the Subcommittee held hearings on Medicare vision reform (Ser. No. 98-141). Testimony was received from 9 witnesses, representing 6 organizations, with additional material submitted by 3 organizations.

On October 17, 1983, the Subcommittee held hearings on the National Organ Transplant Act, H.R. 4080, Title II of which contained Medicare and Medicaid amendments (Ser. No. 98-70). Testimony was received from 10 individuals, representing 9 agencies and organizations, with additional material submitted by 2 individuals.

Committee Consideration

On August 1, 1985, the Committee met in open session and ordered reported the bill H.R. 3101, with amendment, by a recorded vote of 22 to 6, a quorum being present.

Committee Oversight Findings

Pursuant to clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, the Subcommittee held oversight hearings and made findings that are reflected in the legislative report.

Committee on Government Operations

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will reduce budget outlays for fiscal years 1986, 1987, and 1988 by an amount in excess of that estimated by the Congressional Budget Office. The Committee notes that, according to CBO, this bill would reduce Federal Medicare and Medicaid outlays by a total of $511 million in FY 1986, $710 million in FY 1987, and $1.238 billion in FY 1988, a three-year total of $2.459 billion.

The Committee takes issue with the CBO estimate that section 201 of the bill, relating to the expansion of Medicaid coverage for pregnant women in working poor two-parent families, will increase Federal outlays by $100 million over the next 3 years. While CBO did adjust its cost estimates to account for private insurance and for nonparticipation, it did not adjust for the savings in reduced intensive care and long-term institutional costs that can reasonably be expected from the reduction in the incidence of low birthweight births among the target population that greater access to prenatal care should produce. These savings have been conservatively estimated to be in the range of $3 for every $1 invested in prenatal care for this disadvantaged, high-risk population. The Committee to Study the Prevention of Low Birthweight of the Institute of Medicine of the National Academy of Sciences, Preventing Low Birthweight (1985), at 212–237. In the Committee's view, even if its proposal will initially result in outlays, these costs will in subsequent years be more than offset by savings of the magnitude estimated by the IOM Committee.

U.S., Congress,
Congressional Budget Office,
Washington, DC, August 22, 1985.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for H.R. 3101, the Medicare and Medicaid Budget Reconciliation Amendments of 1985, as ordered reported by the House Committee on Energy and Commerce, August 2, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number H.R. 3101.
2. Bill title: The Medicare and Medicaid Budget Reconciliation Amendments of 1985.
3. Bill status: As ordered reported by the House Committee on Energy and Commerce on August 2, 1985.
4. Bill purpose: To amend Titles XVIII and XIX of the Social Security Act to provide for budget reconciliation and improvements, with respect to the Medicare and Medicaid programs.
5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Function 550:					
Budget authority	14	13	20	22	16
Outlays	14	13	20	22	16
Function 570:					
Budget authority	−304	−342	−794	−962	−1,031
Outlays	−525	−723	−1,258	−1,520	−1,693
Total:					
Budget authority	−290	−329	−774	−940	−1,015
Outlays	−511	−710	−1,238	−1,498	−1,677

Basis of estimate

The cost estimate deals with only those sections of the bill that are anticipated to have a budget impact. Table 1 provides a section-by-section analysis of the estimated outlay changes relative to the budget resolution baseline that would result from the enactment of this legislation. The table contains four rows of numbers for each section of the bill. The first, labeled "Medicare Benefits" is the change in benefits due to that section of the bill. The second, labeled "Medicaid", is the effects of that section of federal Medicaid spending. The third row, labeled "Premiums", is the change in premium collections caused by the change in benefits. The final row, labeled "Total", is the net effect of that section of the bill.

TABLE 1.—COST ESTIMATES FOR H.R. 3101

[Outlays by fiscal year, in millions of dollars]

Section and description	1986	1987	1988	1989	1990	1986–88
Title I:						
101 Physician fee freeze:						
Medicare benefits	−215	−240	−300	−310	−320	−755
Medicaid	−5	−7	−8	−8	−8	−20
Premiums	35	46	56	57	54	137
Total	−185	−201	−252	−261	−273	−638

TABLE 1.—COST ESTIMATES FOR H.R. 3101—Continued

[Outlays by fiscal year, in millions of dollars]

	Section and description	1986	1987	1988	1989	1990	1986–88
103	Premiums 25% Program 1988:						
	Medicare benefits	0	0	−407	−568	−603	−407
	Medicaid	0	0	20	28	30	20
	Total	0	0	−387	−540	−573	−387
105	OT expanded service:						
	Medicare benefits	15	20	20	20	25	55
	Medicaid	0	1	1	1	1	2
	Premiums	−3	−4	−4	−4	−4	−11
	Total	12	17	17	17	22	46
106	Freeze DME:						
	Medicare benefits	−50	−90	−125	−165	−225	−265
	Medicaid	−1	−2	−3	−4	−6	−6
	Premiums	8	18	23	30	38	49
	Total	−43	−74	−104	−138	−193	−221
107	Assistant surg/cataracts:						
	Medicare benefits	−25	−30	−30	−35	−35	−85
	Medicaid	−1	−1	−1	−1	−1	−3
	Premiums	4	5	5	5	5	14
	Total	−22	−26	−26	−31	−31	−74
108	Prosthetic lens—cataract:						
	Medicare benefits	−35	−40	−45	−50	−60	−120
	Medicaid	−1	−1	−1	−1	−2	−3
	Premiums	6	8	8	9	10	22
	Total	−30	−33	−38	−42	−52	−101
109	Preventative care demos:						
	Medicare benefits	1	1	1	1	1	3
	Medicaid	(1)	(1)	(1)	(1)	(1)	(1)
	Premiums	(1)	(1)	(1)	(1)	(1)	(1)
	Total	1	1	1	1	1	3
111	Clin lab fee limitations:						
	Medicare benefits	−25	−55	−70	−60	−70	−150
	Medicaid	−1	−2	−2	−2	−2	−5
	Premiums	4	11	13	12	13	28
	Total	−22	−46	−59	−50	−59	−127
112	Vision care:						
	Medicare benefits	20	60	75	85	95	155
	Medicaid	1	2	2	2	3	5
	Premiums	−4	−11	−14	−15	−17	−29
	Total	17	51	63	72	81	131
121	Working aged:						
	Medicare benefits	−230	−360	−400	−460	−520	−990
	Medicaid	−1	−2	−3	−3	−4	−6
	Premiums	6	17	20	22	24	43
	Total	−225	−345	−383	−441	−500	−953
131	Mandatory second opinions:						
	Medicare benefits	−40	−85	−90	−100	−110	−215
	Medicaid	(1)	(1)	(1)	(1)	(1)	(1)

TABLE 1.—COST ESTIMATES FOR H.R. 3101—Continued

[Outlays by fiscal year, in millions of dollars]

Section and description	1986	1987	1988	1989	1990	1986–88
Premiums	−1	−2	−3	−3	−3	−6
Total	−41	−87	−93	−103	−113	−221
132 Changing appears rights:						
Medicare benefits	5	10	10	10	10	25
Medicaid	(1)	(1)	(1)	(1)	(1)	(1)
Premiums	−1	−2	−2	−2	−2	−5
Total	4	8	8	8	8	20
Subtotal title I	534−	−735	−1,253	−1,508	−1,682	−2,522
Title II:						
201 Coverage of pregnant women	20	40	40	45	45	100
202 Community care waivers	(1)	(1)	(1)	(1)	(1)	(1)
203 Optional hospice benefit	(1)	(1)	(1)	(1)	(1)	(1)
204 Reduce direct GME-Medicaid	−5	−15	−25	−35	−40	−45
205 Invalidation of trusts	(1)	(1)	(1)	(1)	(1)	(1)
207 Out-of-State coverage	(1)	(1)	(1)	(1)	(1)	(1)
208 Extension of MMIS deadline	8	0	0	0	0	8
209 Texas 1115 waiver	(1)	(1)	(1)	(1)	(1)	(1)
Subtotal title II	23	25	15	10	5	63
Total H.R. 3101	−511	−710	−1,238	−1,498	−1,677	−2,459

[1] Less than $500,000.

TITLE I—MEDICARE

Section 101. Physician fee freeze

Under current law, the customary and prevailing charges for all physician services are frozen for a 15-month period ending October 1, 1985. During this period many physicians have signed on as participating physicians—meaning that they always agreed to accept these customary and prevailing charges as payment for services rendered under the Medicare program known as "assignment". The physicians that have not agreed to participate must make a decision on each bill as to whether or not they are willing to accept assignment on that bill. During 1985, about 35 percent of Medicare payments for physicians services will be to participants.

This section would continue the distinction between participating and nonparticipating physicians. There are five categories of physicians described in this provision, each of which would be treated differently. The groups are listed below from the most constrained in terms of Medicare reimbursements to the least constrained.

(1) Nonparticipating physicians who do not become participants—The bill would extend the current freeze on customary and prevailing charges for one year.

(2) Participating physicians who become nonparticipants—The bill would limit prevailing and customary charge increases to one half the normal increase in 1986. Thereafter the prevailing charge increase would be lagged one year behind the increase for participating physicians.

(3) Nonparticipating physicians who have always accepted assignment—The bill would limit prevailing and customary charges to one half the normal increase in 1986. The prevailing charges for fiscal year 1987 would be increased 1.5 times the increase that they would normally have received for fiscal year 1986, and thereafter the prevailing charges increase would be lagged one year behind the increase for participating physicians.

(4) Nonparticipating physicians who become participants—This bill would not affect the reimbursements of this group.

(5) Participating physicians who do not become nonparticipants—This bill would not affect the reimbursements of this group.

Savings from this section are based on our estimate that 45 percent of reasonable charges would be charges made by nonparticipating physicians (group 1), 3 percent would be charges for participating physicians who become nonparticipants (group 2), 5 percent would be charges for nonparticipants who always accept assignment (group 3), and 47 percent would be charges for physicians who agree to participate in 1986 (groups 4 and 5). Under current law, CBO projects increases in reasonable charges of 5.3 percent and 3.8 percent for fiscal years 1986 and 1987 respectively. Under this revision, CBO estimates that the net increase would be 2.8 percent and 4.5 percent for fiscal years 1986 and 1987 respectively.

Section 103. Increasing part B premiums

Currently, premiums are set at 25 percent of SMI program costs for calendar years 1986 and 1987, and then are based on COLA's for calendar years 1988, 1989, and 1990. Under this provision, premiums would be set at 25 percent of SMI program costs for calendar year 1988, changing the estimated monthly premium amount from $19.40 to $20.80 for that year.

Section 105. Occupational therapists

This provision gives the same coverage under Medicare Part B for occupational therapists (OT) as is currently allowed for physical therapists (PT) for the three settings. The costs of coverage of OT services under Medicare for the private practice and SNF settings were based on Medicare payment for PT services. The CBO estimate of the federal costs of extending Medicare coverage to OT's in rehabilitation agencies is based on the number of OT's in this particular setting relative to those in skilled nursing facilities.

Section 106. Durable medical equipment

A one-year freeze on customary and prevailing charges for durable medical equipment (DME) furnished on a rental basis and for oxygen therapy services would be effective October 1, 1985. DME accounts for approximately 7 percent of total Medicare reasonable charges. The price increase assumed prior to the freeze for fiscal year 1986 was 6 percent. Beginning October 1, 1986, the increase in prevailing charges for DME would be limited to the Consumer Price Index. Payment would be required on an assignment basis for both rental DME and oxygen therapy services as of January 1, 1986.

Section 107. Assistants surgery services for routine cataract operations

This estimate was based on the Office of the Inspector General (OIG) Audit Report dated June 7, 1985. For the 29 states included in their review, there were about 576,000 cataract operations paid by Medicare for inpatient and outpatient operations during calendar year 1983, of which about 88,000 operations had additional payments for assistant surgeon charges at a cost of approximately $33 million.

Section 108. Prosthetic lens for cataracts

The CBO based its estimate on a General Accounting Office (GAO) study that gathered data from 7 carriers in 1982. The estimate has two components: the savings from a uniform screen limiting the number of replacement lenses that Medicare will pay for and the establishment of a reasonable charge allowance for prosthetic lenses and for the related professional service. The estimated savings are based on cost data contained in the GAO study. CBO extrapolated the data from seven carriers examined in the GAO study to a national estimate.

Section 109. Preventative services demonstrations

The demonstration program will fund no fewer than five demonstrations. Based on proposals submitted to DHHS, the five projects are expected to average $200,000 each for an annual total of $1,000,000.

Section 111. Payment for clinical laboratory services

This provision would change the month of the annual update from July to October and would apply to clinical laboratory diagnostic tests performed on or after July 1, 1986. This provision also provides a regional limitation amount equal to 115 percent of the unadjusted median of all fee schedules effective January 1, 1986, and effective October 1, 1986, the limitation amount would be equal to 110 percent of the median of all the fee schedules.

Section 112. Vision care

Optometrists would be reimbursed for the same services for which Medicare now reimburses ophthalmologists and for which optometrists are licensed to perform in their state. The CBO estimate assumes a 10 percent difference in Medicare reimbursement based on a comparison of Medicare reimbursements for services that are currently covered for ophthalmologists visits and aphakic patient visits to optometrists.

Section 121. Extension of working aged provisioins

Under current law, workers aged 65–69 years must be offered the same health coverage as younger employees. Similarly, employee spouses aged 65–69, must be offered the same coverage as other spouses. For these workers and spouses, Medicare becomes a secondary payor, reimbursing only to the extent that Medicare is more generous than the private insurance. Under current law, workers and spouses 70 and older have Medicare as their primary

payor with employers providing secondary coverage through a "medigap" policy. Section 121 extends the working aged provisions of the Social Security Act to workers 70 years or older and their spouses. Three types of individuals are included in this provision: workers 70 or older, spouses over 65 or workers 70 or older, and spouses over 70 of workers under 65. By making Medicare a secondary payer for these workers and spouses, Medicare outlays would be reduced by an estimated $990 million during the period 1986 to 1988. The CBO estimate is based on an analysis of elderly workers from the Current Population Survey.

Section 131. Mandatory second surgical opinions

Requiring mandatory second opinions for high volume surgical procedures is expected to reduce certain surgeries by 7.5 percent, based on a study by Abt Associates, Inc. The estimated savings are net of the cost of second opinion consultations and administration. Savings during FY 1986 are adjusted for an April 1, 1986 effective date. Although the provision represents net savings to Medicare, the consultations lead to higher outlays for SMI and higher Part B premium collections.

Section 132. Changing appeals rights

Under current law, administrative hearings for Part B of Medicare may occur for amounts in controversy over $100. This provision retains the current fair hearings process for Part B claims appeals for amounts in controversy between $100 to $500. An ALJ hearing will be granted for amounts in controversy above $500 with judicial review available for amounts in controversy above $1,000. Claims of similar services can be aggregated to reach the threshold amount.

The CBO estimated 32,000 fair hearings in FY 1986, of which 55 percent would be appealable to the ALJ. (This percent includes those additional hearings which would occur from aggregation.) Costs of an ALJ hearing and a Part B fair hearing were assumed to be $576 and $300 respectively, yielding a cost of approximately $5 million.

This provision would also allow providers to represent beneficiaries in Part A appeals. Assuming a 25 percent increase (8,800 additional cases) in Part A appeals from providers inducing beneficiaries to file appeals, at a cost of $116 per case for a Part A reconsideration, additional costs of $2.5 million would result.

TITLE II—MEDICAID

Section 201. Services for pregnant women

This section extends Medicaid coverage for pregnant women in intact families not currently covered. Approximately 200,000 women not currently covered would be eligible for Medicaid services when they become pregnant. The 1986 estimate is based on 26,000 pregnancies at $2,650 each. The costs are adjusted for private insurance and nonparticipation. The first year is reduced by 50 percent to allow states the time to implement the new coverage.

Section 202. Modifications of home and community-based waiver under section 1915(c)

This provision would allow home care to be substituted for institutional care for persons requiring vocational, prevocational, and educational services. It would also allow home care to be substituted for hospital care for ventilator dependents. Because the average per capita expenditure for home care could not exceed the average per capita expenditure for institutional care under the waiver restrictions, this section could add to costs only to the extent that additional persons are served. The costs are not expected to be significant.

Section 203. Optional hospice benefits

This section wuld permit states to cover hospice services under state Medicaid programs. Costs for this provision are estimated to be insignificant because much of the care will substitute for hospital or nursing home care with similar or higher costs.

Section 204. Reduce Medicaid payments for graduate medical education (GME)

This estimate assumes that the base period used in determining the allowable average cost per full-time equivalent (FTE) resident in a hospital would be the 1983 Medicare cost report. Since the 1983 data is not yet available, we have based our savings estimate on the 1981 cost reports, projected to 1983. This projection introduces uncertainty into the estimate. Finally, the savings were adjusted to account for a variety of state reimbursement systems, many of which already limit GME payments at or below the level in this provision.

Section 205. Treatment of potential income from Medicaid qualifying trusts

This section would declare certain Medicaid qualifying trusts available as income to beneficiaries for purposes of eligibility determination for Medicaid. These trusts would be ones in which the trustee or trustees are permitted to exercise any discretion with regard to the amount of income to be distributed to the individual. The small number of such trusts estimated to be affected by this provision would lead to an uncertain and perhaps insignificant amount of savings.

Section 207. Deemed residence for out-of-State adoptive and foster care placements

This section would deem Title IV–E recipients who have been placed out of state as residents of the state in which they reside for Medicaid purposes. About 1,000 adoption assistance children and 5,000 to 10,000 foster care children are involved. These children often have difficulty finding a provider who will accept an out-of-state Medicaid card. This proposal could lead to costs because children who are now having difficulty receiving care could more easily receive care. The number of these children now not receiving care is estimated to be small. Therefore, the Medicaid cost of this proposal is expected to be insignificant.

Section 208. Extension of MMIS deadline

This provision would allow an extension of the deadline for having an operational Medicaid Management Information System (MMIS). Only the state of Maryland would be affected. Currently, Maryland is facing an $8 million penalty for having missed the previous deadline. If this proposal were enacted, it would result in a cost to the federal government of that amount.

Section 209. Extension of certain waiver project

This provision would extend for three years a Section 1115 waiver to the state of Texas. On January 1, 1986, when the current waiver ends, there will be an estimated 3,185 grandfathered ICF–II recipients and 2,150 home care recipients no longer covered under Medicaid. If the waiver were not extended, it is possible that many of those ICF–II recipients would receive more expensive ICF care resulting in higher federal expenditures. Some of the now relatively inexpensive home care recipients could also qualify for ICF care which would again lead to higher federal cost while those who did not qualify and would then no longer be receiving care would lead to federal savings. Due to the uncertainty surrounding the waiver recipients eligibility for and access to ICF care in the sbsence of waiver renewal, it is difficult to estimate what costs would be for them. Based upon discussions with Texas officials, we understand that the extension of the waiver is unlikely to increase costs significantly.

6. Estimated cost to the state and local governments: This bill would have the following effects on the costs of state and local government Medicaid programs:

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
State and local Medicaid costs:					
Title I	7	10	4	10	9
Title II	12	20	12	8	4
Total	5	10	16	18	13

Basis of Estimate

Title I would reduce Medicare and Medicaid outlays. Because states share in the financing of Medicaid—paying abut 45 percent of outlays—their Medicaid expenditures also would change. Reductions in Medicare outlays reduce state and local copayments for those beneficiaries with dual Medicare/Medicaid coverage. Title I also increases Medicare premiums. The increased Medicare premiums are a cost to state Medicaid programs. Beginning in FY 1988, the additional premiums are larger than savings from federal Medicare cutbacks.

Title II would increase state and local outlays for Medicaid by requiring states to cover certain pregnant women not currently eligible for Medicaid. these increased state and local outlays are only

partically offset by reductions due to reduced payments for Graduate Medical Education.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Diane Burnside Craig Liske, Anne Manley, and Jack Rodgers.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the bill as reported will have no inflationary impact, but instead will contribute to a reduction in inflationary pressure by lowering projected Federal spending for medical care.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * * * *

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

* * * * * * *

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

Sec. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

* * * * * * *

(8) The organization shall perform such duties and functions and assume such responsibities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part *or as may be required to carry out section 1862(a)(15).*

* * * * * * *

(12) The organization shall perform the referral functions for second opinions described in section 1890(c).

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

[(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies;]

(C) Outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items

and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii) or under the procedure described in section 1870(f)(1)) of the lesser of the amount determined under such fee schedule, *the limitation amount for that test determined under subsection (h)(4)(B),* or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, [and] (F) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, *and (G) with respect to items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services;*

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services (other than durable medical equipment), *items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion),* and to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

* * * * * * *

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), [or to a provider having an agreement under section 1866] to a provider having an agreement under section 1866, or for tests furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion) of the lesser of the amount determined under such fee schedule, *the limitation amount for that test determined under subsection (h)(4)(B),* or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such test;

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services, (3) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(F) or under subsection (i)(2) or (i)(4), [and] (4) such deductible shall not apply with respect to clinical diagnostic labaoratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on the basis of an assignment described in section 1842(b)(3)B(ii), under the procedure described in section 1870(f)(1), or to a provider having an agreement under 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), *and (5) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion).* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quanities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished

such individual shall be deemed replaced when the insitution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under the sentence.

* * * * * * *

(g) In the case of services described in the [next to last] *second* sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b). *In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).*

(h)(1)(A) The Secretary shall establish fee schedules for clinical diagnostic laboratory tests for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a hospital laboratory for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished during the period beginning on July 1, 1984, and ending on [June] *September* 30, 1987. For such tests furnished on or after [July] *October* 1, 1987, the fee schedule shall be established on a nationwide basis.

(C) In the case of clinical diagnostic laboratory tests performed by a hospital laboratory for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished during the period beginning on July 1, 1984, and ending on [June] *September* 30, 1987. For such tests furnished on or after [July] *October* 1, 1987, the fee schedule under subparagraph (A) shall not apply with respect to clinical diagnostic laboratory tests performed by a hospital laboratory for outpatients of such hospital.

(2) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a hospital laboratory for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area (or, effective [July] *July* 1, 1987, for the United States) for the 12-month period beginning July 1, 1984, adjusted annually *(to become effective on October 1 of each year)* by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes. The Secretary may make further adjustments or exceptions to the fee schedules to

assure adequate reimbursement of (A) emergency laboratory tests needed for the provision of bona fide emergency services, and (B) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules, the Secretary shall provide for and establish a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter.

(4) *(A)* In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after January 1, 1986, and before October 1, 1986, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1), or

(ii) after September 30, 1986, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to 110 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice, and

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test performed by a laboratory which is independent of a physician's office or a rural health clinic may only be made on the basis of an assignment described in section 1842(b)(3)(B)(ii), in accordance with section 1842(b)(6)(B), under the procedure described in section 1870(f)(1), or to a provider of services with an agreement in effect under section 1866.

(6) In the case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) * * *

* * * * * * *

(C) in the case of outpatient physical therapy services *or outpatient occupational therapy services,* (i) such services are or were required because the individual needed physical therapy services *or occupational therapy services, respectively,* (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist *or qualified occupational therapist, respectively* providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * * * *

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1961(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g)),* or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g)),* but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * * * *

(i)(1) In the case of an individual who—

[(A) meets the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A),]

(A) has attained the age of 65,

(B) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's current employment, and

(C) has elected not to enroll (or to be deemed enrolled) under this section during the indiviudal's initial enrollment period,

there shall be a special enrollment period described in paragraph (3).

(2) In the case of an individual who—

[(A) meets the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A),

[(B) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period and any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment, and]

(A) has attained the age of 65;

(B)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(B);

(C) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment; and

[(C)] *(D)* has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment,

there shall be a special enrollment period described in paragraph (3).

[(3) The special enrollment period referred to in paragraphs (1) and (2) is the period—

[(A) beginning with the first day of the third month before the month in which the individual attains the age of 70 and ending seven months later, or

[(B) beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later.

whichever period results in earlier coverage.]

(3) The special enrollment period referred to in paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later.

COVERAGE PERIOD

SEC. 1838. (a) * * *

* * * * * * *

[(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to—

[(1) subparagraph (A) of section 1837(i)(3)—

[(A) before the month in which he attains the age of 70, the coverage period shall begin on the first day of the month in which he has attained the age of 70, or

[(B) in or after the month in which he attains the age of 70, the coverage period shall begin on the first day of the month following the month in which he so enrolls; or

[(2) subparagraph (B) of section 1837(i)(3)—

[(A) in the first month of the special enrollment period, the coverage period shall begin on the first day of such month, or

[(B) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which he so enrolls.]

(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—

(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of thatmonth, or

(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

* * * * * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account [months in which

the individual has met the conditions specified in clauses (i) and (iii) of section 1862(b)(3)(A) and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section] *months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv)* by reason of the individual's (or the individuals spouse's) current employment. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligiblity shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January [1988] *1989* shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

(2) Any increases in premium amounts taking effect prior to January [1988] *1989* by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).

(f)(1) If no cost-of-living increase becomes effective under section 215(i) in December of 1985 [or 1986,], *1986, or 1987,* the monthly premium of each individual enrolled under this part for each month in the succeeding year shall (except as otherwise provided in subsection (b)) be the same as the monthly premium (disregarding subsection (b)) of the individual for such December.

(2) If paragraph (1) does not apply to the monthly premiums for 1986 [or 1987,], *1987, or 1988,* if an individual is entitled to monthly benefits under section 202 or 223 for November and for December in the preceding year, and if the monthly premium for that December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 223 shall (except as otherwise provided in subsection (b)) be the greater of—

(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) necessary to make the monthly benefits under section 202 or 223 for that December after the deduction of the monthly premium (disregarding subsection (b)) for that January at least equal to the monthly benefits under section 202 or 223 for the preceding November after the deduction of the premium (disregarding subsection (b)) for that individual for that December, or

(B) the monthly premium (disregarding subsection (b)) for that individual for that December.

For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into

account in determining the monthly benefits to which an individual is entitled under section 202 or 223.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *
(b)(1) * * *

* * * * * * *

(3) Each such contract shall provide that the carrier—
(A) * * *

* * * * * * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is [$100 or more,] *at least $100, but not more than $500,* when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * * * * * *

(4)(A)(*i*) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii) determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983; except that in the case of physician described in subparagraph (E)(i), the Secretary shall not set any level higher than the increase percentage (described in subparagraph (E)(ii)) above the level that was set for the 12-month period beginning July 1, 1983.

(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians services furnished during a 12-month period beginning on or after October 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous fiscal year for physicians who were participating physicians on the last day of that year; except that in the case of a physician described in subparagraph (E)(i), the Secretary shall not set any level higher than the increase percentage (described in subparagraph (E)(ii)) above the level that was set for services furnished during the previous fiscal year for physicians who were participating physicians on the last day of that year.

(B)*(i)* In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983; except that in the case of a physician described in subparagraph (E)(i), the customary charges may not exceed the customary charges that were recognized under this section for the 12-month period beginning July 1, 1983, increased by the increase percentage (described in subparagraph (E)(ii)).

(C)*(i)* In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)*(i)* as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)*(i)*.

(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).

(D)*(i)* In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1985, or October 1, 1986, by a physician [who at no time for any services furnished during the 12-month period beginning October 1, 1984, was a participating physician (as defined in subsection (h)(1))] *who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985,* the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginnnig on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii)(I) In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1986, or October 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on September 30, 1986, except as provided in subclause (ii) the Secretary shall not recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(II) In the case of a physician who was a participating physician on September 30, 1985, the Secretary shall recognize increases in actual charges for services furnished during the 12-month period be-

ginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984, but only to the extent that the percentage of such an increase does not exceed one-half of the percentage increase in the physician's actual charges for services furnished over the period beginning July 1, 1984, and ending September 30, 1985.

(E)(i) With respect to services furnished during a 12-month period beginning on October 1, a physician described in this clause is a physician who is not a participating physician at the time of furnishing the services but who either (I) was a participating physician on September 30 before that period, or (II) accepted payment on an assignment-related basis (as defined in subsection (h)(8)) for all claims received during the immediately preceding 12-month period for services furnished by the physician under this part during that period.

(ii) The "increase percentage" described in this clause is, with respect to a physician for items and services furnished during a 12-month period beginning on October 1, one-half of the percentage increase that otherwise would be applicable to services furnished by the physician if the physician (I) had been a participating physician on the date before the first date of the period, and (II) were to sign up to be a participating physician for items and services furnished during the period.

* * * * * * *

[The bill realigns the margins of subclause (7)(B)(ii)(III) and clause (7)(B)(iii) to conform to the margins of the other subclauses and clauses of the paragraph.]

(7) (A) * * *

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the carrier shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished to patients in such hospital on the basis of an

assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1870(f)(1), the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(8) The Secretary by regulation shall—

(A) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

(B) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.

(9) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(A) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services, and

(B) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.

* * * * * * *

[The following new paragraphs (h)(4)–(h)(6) were formerly paragraphs (i)(2)-(i)(4):]

(h)(1) * * *

* * * * * * *

[2] (*4*) At the beginning of each fiscal year the Secretary shall publish [a directory] *directories (for appropriate local geographic areas)* containing the name, address, and specialty of all participating physicians and suppliers (as defined in [subsection (h)] *paragraph* (1)) *for that area* for the fiscal year. [The] *Each* directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part.

[(3)] (*5*) The Secretary shall promptly notify individuals enrolled under this part of the publication of [such list and directory] *the directories* and shall make [such list and directory] *the appropriate area directory or directories* available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.

[(4)] (*6*) The Secretary shall provide that [the list and directory] *the directories* shall be available for purchase by the public. *The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area.*

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—

(A) a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and

(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which a beneficiary may obtain information on participating physicians and suppliers.

(8) For purposes of this title, a claim is considered to be paid on an "assignment-related basis" if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).

[(i)(1) Each year the Secretary shall publish a list containing the name, address, specialty, and percent of claims submitted with respect to each physician and supplier during the preceding year that were paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1). The Secretary may limit such list to those physicians and suppliers who accepted such an assignment in a certain percentage of such physician's or supplier's billings or who provide at least a certain volume of services, as the Secretary may determine to be appropriate. Such list shall be organized by such geographical area as the Secretary determines, after consultation with carriers, would facilitate the use of such list by individuals enrolled under this part.]

(j)(1) [In the case of a physician who is not a participating physician, the Secretary shall monitor each such physician's actual charges to individuals enrolled under this part for physicians' services furnished during the 15-month period beginning July 1, 1984.] *In the case of a physician who is not a participating physician for items and services furnished during a portion of the 27-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during this part for physicians' services during that portion of that period.* If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, *or, in the case of items and services furnished during fiscal year 1986 by a physician who was a participating physician on September 30, 1985, if such physician knowingly and willfully bills individuals enrolled under this part for actual charges which are more than the increase percentage (which may be recognized under subparagraph (D)(ii)(II)) above such physician's actual charges for the calendar quarter beginning on April 1, 1984,* the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under paragraph (1) *or subsection (l)* are—

(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

of both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is barred from participation in the program under this title pursuant to this subsection.

(k)(1) In determining the customary and prevailing charge levels under the third and four sentences of subsection (b)(3)—

(A) for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement), and

(B) for oxygen therapy services furnished,

during the 12-month period beginning on October 1, 1985, the Secretary shall not set any such level higher than the same level as was set for the 15-month period beginning July 1, 1984. As used in this subsection, the term 'oxygen therapy services' means durable medical equipment, accessories, and supplies for the provision of oxygen therapy in a patient's home.

(2) Payment under this part for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) and for oxygen therapy services may only be made on an assignment-related basis (as defined in subsection (h)(8)) or to a provider of services with an agreement in effect under section 1866.

(3) In the case of durable medical equipment, the prevailing charge levels determined for purposes of clause (ii) of the third sentence of subsection (b) for any 12-month period (beginning after September 30, 1986) may not exceed (in the aggregate) the levels determined under such clause (taking into account paragraph (1), if applicable) for the preceding 12-month period by a percentage which exceeds the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average), as published by the Secretary of Labor, for the 12-month period ending in March of that preceding 12-month period.

(l)(1) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(2) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

* * * * * * *

PHYSICIAN PAYMENT REVIEW COMMISSION

SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the "Director" and the "Office", respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the "Commission"), to be composed of individuals with expertise in the provision and financing of physicians' services appointed by the Director (without regard to the pro-

visions of title 5, United States Code, governing appointments in the competitive service).

(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed no later than December 1, 1985, for a term of three years, exept that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

(3) The membership of the Commission shall include physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly. The Director shall seek nominations from a wide range of groups, including—

(A) national organizations representing physicians, including medical specialty organizations,

(B) organizations representing the elderly and consumers,

(C) national organizations representing medical schools,

(D) national organizations representing hospitals, including teaching hospitals, and

(E) national organizations representing health benefits programs.

(b)(1) The Commission shall make recommendations to the Congress, not later than February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

(2) In making its recommendations, the Commission shall—

(A) consider, and make recommendations on the feasibility and desirability of reducing, the differences in payment amounts for physicians' services under this part which are based on differences in geographic location or specialty;

(B) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

(C) identify those charges recognized as reasonable under section 1842(b) which are signifcantly out-of-line, based on the considerations of subparagraphs (A) and (B);

(D) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

(E) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

(F) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under this part based on (i) the Secretary's study under section 603(b) (2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related groups) and (ii) the Office's report under section 2309 of the Deficit Reduc-

tion Act of 1984 (relating to physician reimbursement under this part);

(G) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

(H) identify those procedures for which an opinion of a second physician should be required before payment is made under this title; and

(I) evaluate the method for calculating the number of full-time-equivalent residents set forth in section 1902(h)(4)(D) and make recommendations regarding revisions in, or alternatives to, that method.

(3) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under subsection (e).

(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

(A Subparagraph (C) (relating to staffing and administration generally).

(B) Subparagraph (D) (relating to compensation of members).

(C) Subparagraph (F) (relating to access to information).

(D) Subparagraph (G) (relating to reports and use of funds).

(E) Subparagraph (H) (relating to periodic GAO audits).

(F) Subparagraph (J) (relating to requests for appropriations).

(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section.

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and.

(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(e)(1) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part or under State plans appoved under title XIX.

(2) In developing the scale, the Secretary shall consider among other items—

(A) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

(B) the recommendations of the Physician Payment Review Commission under subsection (b)(3), and

(C) factors with respect to the input costs for furnishing particular physicians' services, such as—

(i) the differences in costs of furnishing services in different settings,

(ii) the difference in skill levels and training required to perform the services, and

(iii) the time required, and risk involved, in furnishing different services.

(3) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than April 1, 1987. The report shall include recommendations for the application of the scale to payment for physicians' services furnished under this part on or after October 1, 1987.

Part C—Miscellaneous Provisions

definitions of services, institutions, etc.

Sec. 1861. For purposes of this title—Spell of Illness

(a) * * *

* * * * * * *

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

* * * * * * *

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used [at] *as* his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased.

* * * * * * *

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (includ-

ing a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k), (m), and (p)(1) of this section and sections 1814(a), 1832(a)(F)(ii), and 1835 but only if his performance of functions under subsections (k), (m), and (p)(1) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform, [(4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to services related to the condition of aphakia,] *(4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them,* or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

MEDICAL AND OTHER HEALTH SERVICES

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(D) outpatient physical therapy services *and outpatient occupational therapy services;*

* * * * * * *

REASONABLE COST

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care

services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) *on the basis of* the amount otherwise payable under part A with respect to inpatient hospital services.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of section 1861(p) *(including through the operation of section 1861(g))* the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care); [or]

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph) and which are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under arrangments (as defined in section 1861(w)(1)) with the entity made by the hospital[.],

(15) which are for services of an assistant at surgery in a cataract operation unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition; or

(16) furnished in connection with a surgical procedure if a second opinion is required under section 1890 but is not obtained.

(b)(1) * * *

* * * * * * *

(3)(A)(i) Payment under this title may not be made, except as provided in clause (ii), with respect to any item or service furnished in any month during the period described in clause (iii) to an individual [who is under 70 years of age during any part of such month] (or to the spouse of such individual [, if the spouse is under 70 years of age during any part of such month]) who is employed at the time such items or service is furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a group health plan (as defined in clause (iv)) under which such individual is covered by reason of such employment.

* * * * * * *

(iii) The provisions of clauses (i) and (ii) shall apply to an individual only for the period beginning with the month in which such individual becomes entitled to benefits under this title under section 226(a) [and ending with the month before the month in which such individual attains the age of 70] and shall not include any month for which the individual would, upon application, be entitled to benefits under section 226A.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), [and]

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital[.] *, and*

(I) to notify beneficiaries under this title for whom surgery is to be performed of the need to obtain a second opinion if such surgery is a procedure listed pursuant to section 1890.

* * * * * * *

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g)),* or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g)),* but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A *or part B,* shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title or section 1818, or

(C) the amount of benefits under part A *or part B* (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). *Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item.*

[(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.]

(2) Notwithstanding paragraph (1)(C), in the case of a claim arising—

(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or

(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) The Secretary shall annually determine, *and shall publish not later than September 7 before the calendar year concerned—*

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

* * * * * * *

(3) [Payments] *Subject to subsection (c)(7), payments* under a contract to an eligible organization under paragraph (1) or (2) shall

be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

* * * * * * *

(6) [If] *Subject to subsection (c)(7), if* an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

* * * * * * *

(c)(1) * * *

* * * * * * *

(3)(A)(i) * * *

* * * * * * *

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following [a full calendar month after] *the date on which* the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. *In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.*

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. *No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.*

* * * * * * *

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1886(d), and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

* * * * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) * * *

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(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under [section 1869(b) (when the determination is under part A) or section 1842(b)(3)(C) (when the determination is under part B)] *sections 1869(b) and 1842(b)(3)(C) (as may be applicable)* when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

* * * * * * *

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

(b) With respect to a hospital-based skilled nursing facility, the Secretary shall recognize as reasonable the portion of the costs differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations (as determined by the Secretary) resulting from the reimbursement principles under this title, [notwithstanding] *notwithstanding* the limits set forth in paragraph (3) or (4) of subsection (a).

* * * * * * *

SECOND OPINIONS FOR CERTAIN SURGICAL PROCEDURES

SEC. 1890. (a) CONDITION OF PAYMENT.—No payment shall be made under part A or part B with respect to items or services furnished in connection with a surgical procedure listed by the Secretary pursuant to this section unless the individual undergoing the procedure obtains a second opinion as to the necessity and appropriateness of such procedure, in acordance with this section. For purposes of determining whether an opinion is the second opinion, the first opinion must be made by a physician who is qualified to perform the surgical procedure, and the second opinion is any subsequent opinion made by a physician of the appropriate specialty, as determined under subsection (b)(3). Such second opinion need not necessarily agree with the first opinion in order for payment to be made.

(b) SURGICAL PROCEDURES TO WHICH CONDITION APPLIES.

(1) SECRETARY TO ESTABLISH LIST.—The Secretary shall establish a list of not less than 10 surgical procedures to which the requirements of this section shall apply. The Secretary shall establish such list based upon the following criteria:

(A) The procedure is one which generally can be postponed without undue risk to the patient.

(B) The procedure is a high volume procedure among patients who are covered under the programs established under this title, or is a high cost procedure.

(C) The procedure has a comparatively high rate of nonconfirmation upon requesting a second opinion, based upon data available to the Secretary from any sources.

(2) LIST VARIATIONS.—The Secretary may vary the list on a State-by-State basis, or within areas of a State, if data available with regard to volume and costs of procedures suggest that to do so would be cost effective and would better serve the purposes of this section.

(3) LIST TO SPECIFY SPECIALISTS WHO MUST RENDER SECOND OPINION.—The Secretary shall specify, for each procedure on a list established under this subsection, the type or types of board certified or board eligible specialists who must be consulted for the second opinion, based upon the nature of the procedure.

(c) REFERRAL MECHANISM FOR SECOND OPINIONS.—

(1) USE OF PRO AS REFERRAL CENTER.—The Secretary shall enter into or modify contracts with utilization and quality control peer review organizations under which such organizations shall serve as referral centers for second opinions required under this section.

(2) REFERRAL OF PATIENT.—The organization shall maintain a list of physicians qualified to provide a second opinion and shall advise the patient as to which physicians are participating physicians (within the meaning of section 1842(h)) and which physicians have agreed to accept assignment for second opinions. If the patient seeking the second opinion so requests, the organization shall refer such patient to a physician of the appropriate specialty for purposes of providing the second opinion.

(3) FREEDOM OF CHOICE OF PATIENT TO CHOOSE PHYSICIAN.—Subject to paragraph (4), the patient may choose any physician of the proper specialty to provide the second opinion.

(4) PHYSICIANS PROHIBITED FROM PROVIDING SECOND OPINION.—For purposes of this section, a second opinion may not be provided by a physician who is affiliated with, or has any direct or indirect common financial interest with, the physician who rendered the first opinion that the procedure was necessary.

(5) FORWARDING OF RELEVANT MEDICAL RECORDS.—Each such organization shall, if the patient seeking the second opinion so requests, obtain the relevant medical records from the physician who rendered the first opinion that the procedure was necessary, and provide the relevant information to the physician selected by the patient to render the second opinion in such form so as not to identify the physician who rendered the first opinion.

(6) USE OF OTHER ENTITIES AS REFERRAL CENTERS.—(A) If no utilization and quality control peer review organization is available to perform the functions described in this subsection, the Secretary may enter into an agreement with a State or local agency or appropriate private entity to perform such functions.

(B) If a State is utilizing an entity other than a utilization and quality control peer review organization to provide referrals for second opinions for purposes of title XIX, the Secretary may enter into an agreement under this section with such entity (rather than with a utilization and quality control peer review organization) to perform the functions described in this section if the Secretary determines that such arrangement would be more cost effective and would adequately protect the patients receiving benefits under this title.

(C) If the Secretary determines that a utilization and quality control peer review organization is not able to perform the referral services described in this subsection in a manner that adequately protects patients, the Secretary may enter into an agreement with a State or local agency or appropriate private entity to perform such functions.

(d) EXCEPTIONS TO REQUIREMENT.—The requirements of this section shall not apply—

(1) if delay in providing the surgical procedure would result in a risk to the patient;

(2) if no physican is available (within such reasonable limits as the Secretary shall determine by regulation) who is (A) an appropriate specialist, and (B) a participating physician or a physician who has agreed to accept assignment for the second opinion; or

(3) the surgical procedure is to be performed on a patient who is a member of a health maintenance organization or competitive medical plan having a risk-sharing contract with the Secretary under section 1876(g).

(e) DUTIES OF PHYSICIANS, HOSPITALS, AND AMBULATORY SURGICAL CENTERS TO NOTIFY PATIENTS.—

(1) NOTICE.—Any physician, before performing a surgical procedure which requires a second opinion pursuant to this section,

and any hospital or ambulatory surgical center, before a patient is furnished services at the hospital or center in connection with the performance of such a procedure, shall inform the patient in writing of the necessity of obtaining a second opinion, and make available to the patient, or to the entity performing referral services under subsection (c) if so requested by the patient, any medical records available to such physician, hospital, or center that are necessary in order for the patient to obtain such second opinion.

(2) SANCTIONS.—(A) In the case of any physician, hospital, or ambulatory surgical center which fails to notify a patient of the need to obtain a second opinion or fails to make available medical records, as required under paragraph (1), the Secretary may—

(i) impose a civil monetary penalty and assessment, in the same manner as such penalties are authorized under section 1128A(a), or

(ii) in the case of a second or subsequent failure, bar the physician, hospital, or ambulatory surgical center from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d),

or both. No payment may be made under this title with respect to any item or service furnished by a physician, hospital, or ambulatory surgical center during the period when it is barred from participation in the program under this title pursuant to this subsection.

(B) The Secretary may not bar a physician, hospital, or ambulatory surgical center pursuant to subparagraph (A) if such physician, hospital, or ambulatory surgical center is a sole source of essential services in a community.

(C) The Secretary shall take into account access of beneficiaries to physicians' services, hospital services, and other surgical facility services for which payment may be made under this title in determining whether to bar a physician, hospital, or ambulatory surgical center from participation pursuant to subparagraph (A).

(D) In any case where payment under this title is denied by reason of this section, and a physician, hospital, or ambulatory surgical center failed to notify the patient as required by paragraph (1), the Secretary shall, out of any civil monetary penalty or assessment collected from such physician, hospital, or ambulatory surgical center pursuant to this subsection, make a payment to the patient in the nature of restitution for amounts paid by such patient to such physician, hospital, or ambulatory surgical center which otherwise would have been paid under this title.

(f) NOTICE BY SECRETARY.—

(1) NOTICE TO PHYSICIANS, HOSPITALS, AND AMBULATORY SURGICAL CENTERS.—The Secretary shall notify all physicians, all hospitals having agreements under section 1866, and all ambulatory surgical centers having an agreement with the Secretary described in section 1832(a)(2)(F) of the requirements of this section. The notice shall include the applicable list of surgical pro-

cedures to which such requirements apply, and a description of the penalties for failure to notify a patient concerning such requirements.

(2) NOTICE TO BENEFICIARIES.—The Secretary shall provide for periodic notice to all beneficiaries under this title of the requirements of this section, including the applicable list of the surgical procedures to which such requirements apply and information about the availability of the referral services described in this section. The Secretary shall make the applicable lists and information about referral services available at district and branch offices of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to—

(i) * * *

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) * * *

* * * * * * *

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C), [or]

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1915(c) they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will re-

ceive home or community-based services pursuant to a waiver granted by the Secretary under section 1915(c)[;], *or*

(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);

* * * * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A), then—

(i) * * *

* * * * * * *

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through [17](*18*) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

except that (I) the making available of the services decribed in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part of all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to

any other individuals not described, in clause (A) [and] (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, *(V) the making available to all pregnant women covered under the plan of services relating to pregnancy (including pre-natal, delivery, and post-partum services) or to any other condition which may complicate pregnancy shall not, by reason of subparagraph (B), require the making available of these services, or the making available of such services of the same amount, duration, and scope, to any other individuals, and (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals*;

* * * * * * *

(13) provide—

(A)* * *

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1861(b)(1)(O); [and]

(C) for payment for hospice care in the same amounts, and using the same methodology, as used under part A of title XVIII;

(D) for payment to hospitals for direct medical education costs in amounts determined in accordance with subsection (h); and

[(C)] (E) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic uder the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

* * * * * * *

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the Untied States.

For purposes of this title, any individual receiving aid or assistance under any plan of a State approved under part E of title IV shall be deemed to be receiving such aid or assistance from the State in which the individual actually resides.

* * * * * * *

(e)(1) * * *

* * * * * * *

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall be deemed to remain pregnant, for purposes of the provision of all pregnancy-related and post-partum medical assistance under the plan, until the end of the 60-day period beginning on the last day of her pregnancy.

* * * * * * *

(h) PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Instead of any amounts that are otherwise payable under a State plan with respect to the costs of hospitals for direct medical education costs, the State shall provide for payments to hospitals for such costs in accordance with paragraph (3) of this subsection .

(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each residency year beginning on or after July 1, 1985, as follows:

(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, based on data from the most recent available audited cost report of the hospital, the average amount recognized as reasonable under title XVIII for direct medical education costs of the hospital for each full-time-equivalent resident.

(B) UPDATING UP THROUGH JUNE 1985.—The Secretary shall update each average amount determined under subparagraph (A) through June 1985 by the percentage increase in the consumer price index from the midpoint of the cost reporting periods used under subparagraph (A) to the end of December 1984.

(C) AMOUNT FOR RESIDENCY YEAR BEGINNING JULY 1, 1985.—For the residency year beginning July 1, 1985, the approved FTE resident amount for each hospital is equal to the amount determined under paragraph (B) for that hospital updated, to the end of December 1985, by projecting the

estimated percentage increase in the consumer price index during the 12-month period ending with December 1985.

(D) AMOUNT FOR SUBSEQUENT RESIDENCY YEARS.—

(i) GENERAL RULE.—Except as provided in clause (ii), for each residency year beginning after July 1, 1985, the approved FTE resident amount for each hospital is equal to the amount determined under this paragraph for the previous residency year updated by projecting the estimated percentage change in the consumer price index during the 12-month period ending with December of that residency year, with appropriate adjustments to reflect previous under- or over-estimations under this paragraph in the projected percentage change in the consumer price index.

(ii) LIMITATION ON APPROVED FTE RESIDENT AMOUNTS.—The approved FTE resident amount for a hospital for a residency year may not exceed—

(I) for the residency year beginning on July 1, 1986, 175 percent,

(II) for the residency year beginning on July 1, 1987, 150 percent, and

(III) for residency years beginning on or after July 1, 1988, 125 percent,

of the median amounts determined under clause (i) for all the hospitals in the United States for that residency year.

(E) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not have an approved medical residency training program and was not participating in the program under title XVIII for a cost reporting period ending before 1985, the Secretary shall provide, for the first such period for which it has such a residency training program and is participating under this title, for such approved FTE resident amount as the Secretary determines to be appropriate, based on comparable approved FTE resident amounts for similar programs of similar hospitals located in similar areas.

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after October 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicaid patient load (as defined in subparagraph (C)) for that period.

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the sum of the products, for each residency year occurring during the cost reporting period, of—

(i) the fraction of that residency year that occurs during the period,

(ii) the hospital's approved FTE resident amount (determined under paragraph (2)) for that residency year, and

(iii) the number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that year.

(C) MEDICAID PATIENT LOAD.—As used in subparagraph (A), the term "medicaid patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the reporting period which are attributable to patients with respect to whom payment may be made under the State plan approved under this part.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that time so spent by a resident under an approved medical residency training program in an outpatient clinic, facility of a health maintenance organization, or other ambulatory setting shall be counted towards the determination of full-time equivalency.

(C) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a residency year with a hospital or simultaneously with more than one hospital.

(D) WEIGHTING FACTORS FOR PRIMARY CARE AND OTHER SPECIALTIES.—Subject to subparagraphs (E) and (F), such rules shall provide, in calculating the number of full-time-equivalent residents in approved residency program for residents in approved residency program for residency years beginning on or after July 1, 1987, for the application of a weighting factor for residents determined in accordance with the following table:

For the residency year beginning in—	*The weighting factor for each*		
	(i) primary care resident is—	*(ii) other resident—*	
		(I) during the initial residency period is—	*(II) during any other period is—*
1987	*1.10*	*.90*	*.75*
1988	*1.20*	*.80*	*.50*
1989 or later	*1.30*	*.70*	*.50*

(E) ALTERNATIVE COMPUTATIONS OF FULL-TIME EQUIVALENTS.—For residency years beginning on or after July 1,

1989, the Secretary may change the weighting factors described in the table in subparagraph (D) or may establish alternative methods for calculating the number of full-time equivalent residents, based on recommendations of the Physician Payment Review Commission (established under section 1845).

(F) SPECIAL RULES FOR FOREIGN MEDICAL GRADUATES.—

(i) REQUIRED TO PASS FMGEMS EXAMINATION.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (b)(D)), the individual shall not be counted as a resident for a residency year beginning on or after July 1, 1986, unless the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)) before the beginning of the residency year.

(ii) TRANSITION FOR CURRENT FMGS.—For the residency year beginning on July 1, 1986, in the case of a foreign medical graduate who—

(I) has served as a resident before that year and is serving as a resident during that year, but

(II) has not passed the FMGEMS examination before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(iii) TREATMENT OF CERTAIN ECFMG-CERTIFIED INDIVIDUALS.—For purposes of this subparagraph, the Secretary may provide for an individual to be treated as having passed the FMGEMS examination if the individual is unable to take that examination because the individual has previously received certification from the Educational Commission for Foreign Medical Graduates.

(5) DEFINITIONS.—As used in this subsection:

(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) CONSUMER PRICE INDEX.—As used in this paragraph, the term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) DIRECT MEDICAL EDUCATION COSTS.—The term "direct medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) FOREIGN MEDICAL GRADUATE.—The term "foreign medical graduate" means an individual who is a graduate of a medical school not accredited by a body or bodies approved for this purpose by the Secretary of Education (re-

gardless of whether the school of medicine is in the United States).

(E) FMGEMS EXAMINATION.—The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose.

(F) INITIAL RESIDENCY PERIOD.—The term "initial residency period" means, in the case of a resident, the minimum number of years of formal training necessary to satisfy the requirements (as specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education) for initial board eligibility in the particular specialty for which the resident is training; except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of residency of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is a resident in the field of geriatric medicine or the field of public health and preventive health shall not be counted towards the initial residency period.

(G) PRIMARY CARE RESIDENT.—The term "primary care resident" means an individual during the individual's first three years of postgraduate medical training in the field of internal medicine, pediatrics, or family medicine, but does not include such an individual who—

(i) has been accepted for postgraduate medical training in a field other than internal medicine, pediatrics, family medicine, geriatric medicine, or public health and preventive medicine, and

(ii) is receiving such training as part of the initial training for that field.

Such term also includes an individual during up to two years of postgraduate medical training in the field of geriatric medicine or the field of public health and preventive medicine.

(H) RESIDENCY YEAR.—The term "residency year" means a 12-month period beginning on July 1.

(I) RESIDENT.—The term "resident" includes an intern or other participant in an approved medical residency training program.

* * * * * * *

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa for care and services described in paragraphs (1) through [(18)] *(19)* of section 1905(a).

(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17), is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term "grantor" means the individual referred to in paragraph (2).

(2) For purposes of this subsection, a "medicaid qualifying trust" is a trust, or similar legal device, established by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(3) This subsection shall apply without regard to—

(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this title, or

(B) whether or not the discretion described in paragraph (2) is actually exercised.

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike, and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan.

* * * * * * *

(r)(1)(A) * * *

(B) The deadline for operation of such systems for a State is [the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted before the date of the enactment of this subsection.] *September 30, 1985.*

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physi-

cians' or dentists' services, at the option of the State, or individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance made available to individuals described in section 1902(a)(10)(A) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI.

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to pariticipate in the State plan program established under title XVI, or

(viii) pregnant women

but whose income and resources are insufficient to meet all of such cost—

(1) * * *

* * * * * * *

(17) services furnished by a nurse-midwife (as defined in subsection (m)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider; [and]

(18) hospice care (as defined in subsection (o)); and

[(18)] *(19)* any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

* * * * * * *

(n) The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of title IV (or would be eligible for such aid if coverage under the State plan under part A of title IV included aid to families with dependent children of unemployed parents pursuant to section 407) if her child had been born and was living with her in the month such

aid would be paid, and such pregnancy has been medically verified[; or],

(B) is a member of a family which would be eligible for aid under the State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid pursuant to such section[; and], *or*

(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and

* * * * * * *

(o)(1) The term "hospice care" means the care described in section 1861(dd)(1) furnished by a public, or private nonprofit, hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to receive hospice care instead of certain other benefits (described in section 1812(d)(2)) under the plan.

(2) An individual's voluntary election under this subsection—

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2),

(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish, and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

Sec. 1915. (a) * * *

* * * * * * *

(c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan *or but for the provision of such services the individuals would continue to receive inpatient hospital services because they are dependent on ventilator support the cost of which is reimbursed under the State plan.*

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) * * *

* * * * * * *

(C) such individuals who are determined to be likely to require the level of care provided in a *hospital or* skilled nursing facility or intermediate care facility are informed of the feasi-

ble alternatives, if available under the waiver, at the choice of such individuals, to the provision of *inpatient hospital services or* skilled nursing facility or intermediate care facility services;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed *100 percent of* the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

* * * * * * *

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met. *A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.*

* * * * * * *

(5) For purposes of paragraph (4)(B), the term "habilitation services", with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings, and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services, but

(C) does not include—

(i) special education and related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency, and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in

order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those facilities.

* * * * * * *

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. (a) The State plan shall provide that in the case of individuals described in section 1902(a)(10)(A) who are eligible under the plan—

(1) * * *

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) * * *

* * * * * * *

(C) services furnished to any individual who is an impatient in a hospital, skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, [or]

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled[; and], *or*

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

* * * * * * *

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. 1919. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law that make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

(B) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(C) Section 414(g) of this Act (relating to certain individuals participating in work supplementation programs).

(2) SSI.—Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(3) REFUGEE ASSISTANCE.—Section 412(e)(5) of the Immigration and Nationality Act (relating to medical assistance for certain refugees).

(4) MISCELLANEOUS.—(A) Section 230 of Public Law 93-66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93-66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93-66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93-233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94-566 (popularly known as the "Pickle Amendment", relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(b) ADDITIONAL STATE PLAN REQUIREMENTS.—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of Public Law 93-66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).

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SECTION 2306 OF THE DEFICIT REDUCTION ACT OF 1984

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DIVISION B—SPENDING REDUCTION ACT OF 1984

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TITLE III—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH AMENDMENTS

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Subtitle A—Medicare Amendments

PART I—REIMBURSEMENT AND BENEFIT CHANGES

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LIMITATION ON PHYSICIAN FEE PREVAILING AND CUSTOMARY CHARGE LEVELS; PARTICIPATING PHYSICIAN INCENTIVES

SEC. 2306. (a) * * *

(b)(1) Section 1842(b)(3) of such Act is amended—

(A) in subparagraph (F), by striking out "June 30" and inserting in lieu thereof "September 30";

(B) by striking out "July 1" each place it appears in the third and eighth sentences and inserting in lieu thereof in each instance "October 1"; and

(C) in the third sentence thereof, by striking out "during the last preceding calendar year elapsing prior to" and inserting in lieu thereof "during the 12-month period ending on the March 31 last preceding".

(2) The amendments made by paragraph (1) shall apply to items and services furnished on or after October 1, 1985, *and to durable medical equipment furnished on or after July 1, 1985.*

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(e) In addition to any funds otherwise provided for fiscal years 1984 [and 1985], *1985, and 1986* for payment to carriers under contracts entered into under section 1842 of the Social Security Act, there are transferred from the Federal Supplementary Medical Insurance Trust Fund, for payments to such carriers under such contracts to implement [the amendments made by this section,] not less than $8,000,000 for fiscal year 1984, and not less than $15,000,000 *for each of fiscal years 1985 and 1986. A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program.*

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AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967

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PROHIBITION OF AGE DISCRIMINATION

SEC. 4. (a) * * *

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(g)(1) For purposes of this section, any employer must provide that any employee aged 65 [through 69], *or older,* and any employee's spouse aged 65 [through 69], shall be entitled to coverage under any group health plan offered to such employees under the

same conditions as any employee, and the spouse of such employee, under age 65.

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AGE LIMITATION

SEC. 12. (a) The prohibitions in the Act *(except the provisions of section 4(g))* shall be limited to individuals who are at least 40 years of age but less than 70 years of age.

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MINORITY VIEWS ON H.R. 3101—MEDICARE AND MEDICAID BUDGET RECONCILIATION AMENDMENTS OF 1985

OVERVIEW

We are compelled to register our strong opposition to H.R. 3101, the Medicare and Medicaid Budget Reconciliation Amendments of 1985 for several specific reasons. First, this bill falls far short of achieving the savings targets which the House-passed budget resolution (H. Con. Res. 152) and the budget resolution adopted by both the House and Senate on August 1, 1985 (S. Con. Res. 32) have instructed the Committee on Energy and Commerce to achieve.

Second, the minimal savings that are achieved through changes in the health care entitlement programs are significantly reduced by several measures which actually increase Federal spending in both the Medicare and Medicaid programs. While there may be merit to the spending proposals contained in H.R. 3101, a reconciliation bill is an inappropriate context in which to incorporate them.

Third, the Committee had an opportunity to make real savings in programs within its jurisdiction other than Medicare and Medicaid but this opportunity was passed up by our colleagues. Thus, the reconciliation package reported by the Committee makes negligible savings when measured against the Committee's instructions. We believe that the American people regard reducing the federal budget as one of the Nation's highest priorities. To forgo an opportunity to pursue legislation that would have resulted in billions of dollars of savings flies in the face of reason and logic.

For these reasons we opposed H.R. 3101 when it was reported by the Committee. What follows for the benefit of our colleagues is an analysis of the shortcomings of H.R. 3101 and why it is appropriate for the Committee meet again to mark up legislation which complies with its budget instructions.

ANALYSIS OF COMMITTEE ACTION

On August 1, 1985, the Committee ordered reported H.R. 3101 as its effort to comply with the reconciliation instructions of the House-passed budget resolution (H. Con. Res. 152). H. Con. Res. 152 required the Committee on Energy and Commerce and the Committee on Ways and Means to jointly reduce outlays by a total of $12.8 billion over three years. While the Committee on Ways and Means reported a bill (H.R. 3128), which achieved close to $10 billion in savings, H.R. 3101 as reported by this Committee achieves additional net savings over H.R. 3128 of only $141 million.

Although H.R. 3101 contains measures which will save more than $400 million dollars over and above savings achieved by the Ways and Means Committee, it also contains spending provisions which when subtracted from the savings measures yields a net sav-

ings of $141 million or an average of $47 million per year over the Ways and Means bill. While these spending provisions may have merit, we question the appropriateness of their inclusion in reconciliation legislation.

We are disappointed that the Energy and Commerce Committee in reporting H.R. 3101 has not met its responsibility in achieving needed budget savings. Given the vast jurisdiction the Committee has over many expensive Federal programs, it is a sad commentary that its contribution to reduction of the deficit is so meager.

During Full Committee mark-up of H.R. 3101, the Minority attempted to have the Committee consider legislation that would effectuate more substantial savings. This legislation was drafted to incorporate changes in several discretionary programs under the Committee's jurisdiction. It was our intent in proposing this vehicle to substantially reduce this country's $200 billion deficit through changes in several energy and transportation programs rather than making health care entitlements programs the exclusive source of savings. The alternative we attempted to put before the Committee incorporated several legislative proposals already endorsed by this Committee. For example, the Committee is on record in support of reductions in the authorization levels for the Nuclear Regulatory Commission, and Amtrak as well as the complete elimination of the Synthetic Fuels Corporation. In addition, this legislative package incorporated responsible budgetary reduction measures which reflected a prudent approach to meeting our Nation's energy needs by amending such programs as the Strategic Petroleum Reserve, the Federal Energy Regulatory Commission and energy research and development.

The rule (H. Res. 231) which required the Committee on Energy and Commerce to comply with the reconciliation instructions of H. Con. Res. 152 specifically states that it would cease to apply once the House and Senate passed the First Concurrent Budget Resolution for FY 1986. On August 1, 1985 this occurred when the House and Senate passed the Conference Report on S. Con. Res. 32. This further substantiates our arguments that H.R. 3101 is neither substantively or procedurally a legitimate component of the budget reconciliation process.

We believe the legislation we attempted to have considered at Full Committee in lieu of H.R. 3101 now deserves consideration by the Committee. Our alternative budget reconciliation package achieves close to $14 billion in budget savings. We believe that given opportunity, the Committee could report legislation that contains the savings called for in S. Con. Res. 32.

CONCLUSION

This Committee has an obligation to the American people to make a realistic contribution to cutting our Nation's deficit. This can only be done through a serious legislative package that will substantially reduce Federal Spending. H.R. 3101 falls far short of meeting the reconciliation instructions of the budget resolution now in place. What minimal savings that are achieved in the bill through changes to the Medicare program are reduced by spending measures that expand Medicaid and Medicare services. This is ina-

propriate for budget recondiliation legislation. It is time for the Members of this committee to take the budget process seriously. Clearly, the bill our colleagues voted to report to the House is not a legitimate budget-cutting vehicle.

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